RECOVERY ADVOCACY

Recovery Advocacy and the New Recovery Movement

William L. White — Selected Papers, Volume II

77 Papers

White's foundational writings on the new recovery advocacy movement — from its origins to its vision for transforming addiction treatment and recovery support in America.

Papers by William L. White, freely shared for educational use.
Source: William White Library, Chestnut Health Systems / Lighthouse Institute
chestnut.org/li/william-white-library

TABLE OF CONTENTS

RECOVERY ADVOCACY — AND THE NEW RECOVERY MOVEMENT

No.	Title	Year
1	In Praise of Service	1993
2	Bill Moyers interviewing Bill White	1998
3	Recovering People as Wounded Healers I	2000
4	Recovering People as Wounded Healers II	2000
5	Toward a New Recovery Movement	2000
6	Campus as a Recovery Community	2001
7	New Recovery Advocacy Movement: Call to Service	2001
8	Recovery Summit Closing Speech	2001
9	Rhetoric of Recovery Advocacy	2001
10	Recovery as a Heroic Journey	2002
11	Peer Recovery Support Services	2004
12	Radical Recovery	2004
13	A New Recovery Advocacy Movement	2005
14	Recovery Advocacy Is NOT A Recovery Program	2005
15	Treatment Recovery Community	2005
16	Treatment Recovery Community	2005
17	A New Recovery Advocacy Movement	2006
18	A Recovery Revolution in Philadelphia	2007
19	Betty Ford Institute Recovery Definition	2007
20	Defining the Recovery Community Organization	2007
21	New Addiction Recovery Advocacy Movement Essay	2007
22	New Addiction Recovery Advocacy Movement Essay	2007
23	Recovery Community Linkage Monograph	2007
24	Women's Recovery Community Center	2007
25	Authenticity of Recovery Community Organizations	2009
26	Peer-Based Recovery Support Services	2009
27	Recovery Revolution Children & Adolescents	2009
28	Addiction Recovery Support Services	2010
29	Critique of UK Recovery Movement	2010
30	Message to UK Recovery Academy	2010
31	Non-clinical Recovery Support Services	2010
32	Recovery-oriented Methadone Maintenance	2010
33	Bamber-White Dialogue I: Recovery-Oriented Methadone Maintenance	2011
34	Bamber-White Dialogue II Inside the Recovery Revolution	2011
35	Emerging UK Recovery Movement	2011
36	Recovery-oriented Methadone Maintenance Executive Summary	2011
37	Commentary on Service Integration Iniatiatives	2012
38	Comparing Cancer Treatment & Addiction Treatment	2012
39	Historical Perspectives on Addiction Recovery Support	2012
40	History of Recovery Orientation in Addiction Counseling	2012
41	Is it Time We Became Recovery Professionals	2012
42	Japan Recovery Parade Report	2012
43	New Addiction Recovery Support Institutions	2012
44	Recovery Carriers	2012
45	Recovery Orientation in Methadone Maintenance	2012

46	Recovery/Remission from Substance Use Disorders: An Analysis of Repor...	2012
47	Betty Ford Institute Consensus Statement on Recovery Support Services	2013
48	Chronology of New Addiction Recovery Advocacy Movement	2013
49	Community as Patient Recovery-focused Community Mobilization	2013
50	Heroism and Addiction Recovery Revisited	2013
51	Myths to Recovery By	2013
52	Recovery Champions in the UK	2013
53	Recovery Focused Knowledge	2013
54	Recovery Orientation in Addiction Counseling	2013
55	Recovery Prevalence and Health Profile of People in Recovery	2013
56	Recovery Prevalence and Health Profile of People in Recovery	2013
57	Recovery and Harm Reduction In Philadelphia	2013
58	State of the New Recovery Advocacy Movement	2013
59	Systems Perspective on Recovery-oriented Practice	2013
60	Systems Perspective on Recovery-oriented Practice	2013
61	Recovery Agenda, Shared Role of Peers and Professionals	2014
62	Recovery Support for Adolescents with Substance Use Disorders	2014
63	The Recovery Community Center	2014
64	Tribute to the Recovery Movement	2014
65	Young People in the New Recovery Advocacy Movement	2014
66	Congress 60 Recovery Community in the Islamic Republic of Iran	2015
67	LGBT and Recovery Advocacy Movements	2015
68	Smoking Cessation within Iranian Recovery Community (Congress 60)	2016
69	Recovery's Historian Counselor Interview of William White	2017
70	Recovery Revolution Basics	2019
71	Recovery Revolution Basics	2019
72	Volunteer Recovery Support for Adolescents Design	2019
73	New Recovery Advocacy Movement: A Twenty-Year Retrospective	2021
74	Personal Privacy and Public Recovery Advocacy	2021
75	Reflections on the Anniversary of the 2001 Recovery Summit	2021
76	Volunteer Recovery Support for Adolescents Outcomes	2022
77	Frontiers of Recovery Research	2024

In Praise of Service: A Call for Self-Inventory and Self-Renewal In the 1990s *

A Lighthouse Institute Monograph

William L. White, M.A.
Lighthouse Institute
Bloomington, Illinois

* An elaboration of keynote addresses presented at:

1. The 37th Summer Midwest Institute on Alcohol and Drug Abuse Training, July 14-19, 1991, Decatur, Illinois. Sponsored by: Illinois Department of Alcoholism and Substance Abuse, Indiana Department of Mental Health, Michigan Office of Substance Abuse Services and the Wisconsin Department of Health and Human Services.
2. The IADDA Fall Conference, November 20, 1991, Springfield, Illinois. Illinois Alcoholism and Drug Dependence Association.

Published by the Lighthouse Institute

Bloomington, Illinois

© 1993 William L. White

All Rights Reserved. No part of this publication may be reproduced in any form or by any means without permission in writing from the author.

Additional copies of this publication may be obtained by sending $ 5.95 plus $ 2.00 shipping and handling to:

Lighthouse Institute Publishing
702 West Chestnut Street
Bloomington, Illinois 61701
(309) 827-6026

Other books by William White available from the Institute include:

The Call to Write: An Invitation for Aspiring Writers (with Pamela Woll) (1995)

Incest in the Organizational Family: The Ecology of Burnout in Closed Systems (1986)

Critical Incidents: Ethical Issues in Substance Abuse Prevention & Treatment (1993)

The Culture of Addiction, The Culture of Recovery (1990)

The Training Life: Living and Learning in the Substance Abuse Field (with Bruce Joleaud, Felicia Dudek and Bob Carty) (1994)

In Praise of Public Service:
A Call for Self-Inventory and Self-Renewal in the 1990s

William L. White

I. Introduction

It is a pleasure and an honor for me to be here today. Through my training, research and consulting activities I have the privilege of being able to talk to substance abuse prevention and treatment professionals from all over Illinois and around the country—to hear of their concerns about where we are as a field and where we are going. What I hope to do in the next hour is to articulate concerns that are being expressed within the field with increasing frequency and intensity. I want to use my voice to pass on concerns of persons who would not likely be afforded, nor who would want, the visibility of this podium.

The voices I hear within the field depict a field at a critical turning point. They depict a field in crisis—facing threats that could fundamentally alter the character of the field. While the crisis is being described in most quarters as a financial crisis, more and more persons I hear are depicting this crucial period as a spiritual crisis—a crisis in values. While the field is speaking of this crisis in terms of restrictive third party coverage, HMOs, managed care, Medicaid cuts and so forth, I will describe this crisis using terms like mission, vision, values, ethics, and commitment. I will suggest that the centerpiece of this crisis is the changing value attached to service within our culture and within our field of professional endeavor.

The crisis I am speaking of has emerged out of two decades of unprecedented success within our field, and what a period of success it has been. Who could imagine the current status of our field when only a few short years ago alcoholics and addicts were institutionalized, lobotomized, electroshocked, hydrotherapied, drugged beyond coherence and consciousness, restrained and secluded—all in the name of humane intervention? Who could imagine our status today when only a few short years ago their was no community-based system of substance abuse prevention and treatment services? It was so recent—before we decriminalized public intoxication—that alcoholics were routinely banished into drunk tanks where many died of acute illnesses or were found hanging in their cells. Who could have predicted that hospitals that twenty years ago wouldn't admit alcoholics and addicts for acute medical care would open and aggressively

© William L. White, 1993

market new chemical dependency units? From the days when only late stage addicts saw the light of treatment, who could have predicted that we would have EAP and SAP and family intervention technologies and heightened public awareness that would bring whole new generations of clients to treatment before they had lost everything? Who could have predicted that we would have president's wives and every other manner of celebrated figure on television speaking openly about their addiction, treatment, and on-going recovery? Who could have predicted that communities that boasted five AA meetings per week 20 years ago could now list a hundred such meetings along with uncountable adaptations of the 12 step program for problems other than alcoholism? Who could have predicted such an aggressive campaign to stigmatize and criminalize drinking and driving in this country? Who could have predicted the long-coming breakthrough perception of nicotine as an addictive and lethal drug? Who could have predicted areas of the country in which people would openly confess their alcoholism and recovery—it would be a fad in some places—while shamefully hiding their smoking? Who could have predicted that we would begin to focus on the special needs of women and people of color and persons with concurrent physical or psychiatric disabilities as an essential element of our mission? Who could have predicted the force and spread of the COA movement? Who could have predicted that our sustained prevention efforts would see a decrease in the number of illicit drug consumers and smokers in the United States? Who could have predicted that we would bring doctors, nurses, psychologists, social workers and scientists and others back into what is now a legitimate component of our health care system? We've come so far! What crisis could threaten such unparalleled progress?

It is paradoxical that this very same success fertilized the ground from which our current crisis springs. The crisis has emerged out of the excesses of our explosive growth and our industrialization. The signs of this crisis can be seen in many quarters.

- Occupancy rates in private and hospital-based chemical dependency units have dropped precipitously in many areas, while waiting lists in public sector programs treating clients less financially blessed are unconscionably long.
- After the explosive proliferation of new substance abuse programs, private sector programs are being closed, reorganized, or merged in unprecedented numbers.
- Morale of staff within the field has eroded over the past decade, contributing to excessively high rates of staff turnover for direct service workers. A recent study of

© William L. White, 1993

the region of Illinois this conference is being hosted in revealed a 40% annual turnover of substance abuse counselors.

- There is a new form of staff turnover—older, historically committed workers with significant tenure in the field are leaving professional roles. When interviewed they speak of something being lost in the field. Some paradoxically say they are leaving to try to recapture the original spirit of service that brought them into the field.
- There is a crisis of public confidence in our field. Exposes of financial exploitation and other client abuses have led the citizens of our communities to look at us with a more suspicious eye. Talk of "treatment ripoffs" among active alcoholics and addicts adds one more obstacle to entry into treatment and degrades our image in the minds of our most important constituents.
- There is a growing feeling among workers that the identity and character of our field is being shaped externally rather than internally—that we are not in control of our own fate.

Today we will explore the roots and nature of this crisis and create both a vision of where we need to go and an agenda that can help us use this crisis to revitalize our field.

II. A Cultural Context

There is a broader cultural context to the current crisis within the substance abuse field. Commentators from many disciplines have called our attention to fundamental changes occurring in social structures within the United States. Changes in nuclear family structure, decreased contact with extended families, the loss of neighborhood, and the strain on community institutions—our churches, our schools, our workplaces—all bear testament to the dissipation of the social glue that has bound us to one another. Out of these weakening social structures has come a decreased clarity of values and a decreased capability to transmit values. Most noteworthy among these value shifts is the movement away from social duty and obligation—a belief in the nobility of sacrifice for something beyond the self—to a celebration of self-interest, self-exploration, self-indulgence. The "WE-ness" of our culture has disintegrated over two decades into "I-ness." This trend has been well documented beginning with Christopher Lasch's *The Culture of Narcissism* in 1979 and culminating in the publication of Robert Bellah and

© William L. White, 1993

associates' wonderfully illuminating study, *Habits of the Heart*. Both of these books document this shift in values and the resulting loss of connectedness and loss of community. The emergence of greed and materialism has been portrayed on the screen in movies such as *Wallstreet* and in works of fiction such as Tom Wolfe's *Bonfire of the Vanities* and in real life headlines of insider trading scandals, the savings and loan disaster, and the fall from grace of a wide assortment of business, political and religious figures.

Tom Wolfe tells a particularly poignant story that illustrates this transformation in values. Wolfe was walking through the streets of New York doing background research for his book and observed some young men walking towards him, each wearing a peace symbol around his neck. Wolf was positively struck by this sight of young men who in the late 1980s who were visibly exhibiting political consciousness and concern about war and peace. As the young men got closer, Wolfe realized these youthful icons were not peace symbols, but the hood ornaments from Mercedes-Benz' worn on thick gold chains. The Mercedes-Benz hood ornament hanging on a gold chain we could take as the symbolic backdrop to introduce the more detailed exploration of the spiritual crisis within the substance abuse field.

No Professional discipline is immune from such overwhelming social currents. These social currents set the context for our discussion today. To bridge the gap between culture and professional discipline, I would like to tell a story that I have overheard with overwhelming repetition the past two years within the substance abuse lecture circuit. I'm going to tell it for the one or two of you who may have missed it. As an amateur anthropologist, I believe you can tell a lot about a professional field by listening to the nature of its storytelling. See what you think this story tells us about ourselves.

> There were two neophyte hunters who went to the north country to hunt bear. Neither of them had hunted anything before, let alone bear, but typifying the grandiosity of the eighties, each had the latest and most expensive weapons of destruction and were confident of their triumph over the beasts. On the afternoon of the second day, they were becoming quite tired from a prolonged trek up a mountain trail. Rounding a sharp bend, the two hunters suddenly found themselves staring into the face of a bear whose prodigious size, close proximity and sudden ill-temper so startled them that they dropped their guns and began tearing down the mountain trail for their very lives.

© William L. White, 1993

> Their terror was intensified by the sounds of enraged bellowing and breaking branches coming from behind them. Suddenly as if inspired one of the hunters threw himself on the ground, tore off his boots, reached frantically into his back pack and began tying on his tennis shoes. His standing partner screamed at him in disbelief: "Those shoes aren't going to help you outrun the bear!" Jumping from the ground into a full sprint, the tennis-shoed hunter shouted back, "I don't have to outrun the bear; I just have to outrun you!"

Does anyone wonder why this story has suddenly become so popular within our field? Many of us in this field have felt the breath of the bear and have reached for our tennis shoes during the last decade.

III. The Elements of Crisis

There are at least five elements that make up the building blocks of the current crisis of values of which I speak today.

A. Rapid and Turbulent Change

The first of these elements involves the experience of rapid and turbulent change within the substance abuse field. That change—most notably our explosive growth over the past two decades—as noted earlier, has come from our success. The field was not prepared for the sheer speed and scope of this growth. We historically brought new people into the field through a guild system wherein newcomers served informal apprenticeships under the sage guidance of experienced mentors. The speed of our growth outstripped our capacity to mentor—to transmit history, traditions, and values. Our values were further diluted by excessively high staff turnover through which we regularly bled out accumulated knowledge and experience. Noting this transience and lack of continuity of personnel, workers say to me: "How can we expect clients to bond to an environment to which we can't even hold paid staff?" As we have grown larger, the culture within the field has weakened. We are a field in motion whose working constituents are calling for us to stop and define who we are and where we are going.

B. Competition and Isolation

© William L. White, 1993

The second element that set the stage for our crisis in values was the competition that emerged from the proliferation and oversaturation of service providers in many areas.

The first effect of this sustained competition and struggle for survival has been a growing concern about breaches of ethical conduct related to business and clinical practices within the field. Such concerns include aggressive client recruitment processes, the overdiagnosis of chemical dependency (particularly with adolescents), fraudulent business practices and unethical marketing practices. Ethical concerns about how CD services are marketed, for example, include:

- misrepresentation of the scope and intensity of program services,
- superficial specialization—the announcement of a new cocaine treatment track that upon close examination is a new movie and an exercise bike,
- exaggerated claims of success (Inebriate asylums of the late 1800s often boasted cure rates exceeding 90%; if clients left and never came back, they were assumed cured—no news was good news. Some claims of success rates today may be using technology only a notch or two above that of these early predecessors.),
- television and radio adds that unduly exploit the pain and guilt of family members, and
- the exploitive use of clients in the marketing of program services.

Are we on the verge of blue light specials, two for one sales, rebates or seasonal discounts? Adds for chemical dependency treatment that reflect such aggressiveness and poor taste damage the credibility and integrity of the profession.

A second effect of competition has been increased isolation of organizations within the field. Programs became increasingly isolated as competition replaced cooperation between agencies and as the responsibility for relationship-building with local communities was turned over to marketing professionals. When I wrote many years ago about the increasing prevalence of incestuously closed organizations within the substance abuse field, I made the following observation.

© William L. White, 1993

> We barricade ourselves within professional and social communes isolated from the outside world and boldly challenge our clients to reenter the life of communities from which we have long ago lost touch.

This propensity for closure and isolation has intensified in the years since those words were first written. We have fragmented and isolated the whole field of human services into specialties—organizing each agency around an individual disorder or symptom—on the assumption that clients would cooperate and have only one problem at a time. Such fragmentation has left us woefully ill-prepared for the growing number of clients who present with multiple problems and a host of environmental obstacles complicating their entrance into stable recovery.

C. Preoccupation with Profit and Regulatory Compliance

The third building block of our current crisis is a fifteen year obsession with profit and regulatory compliance.

The folk wisdom of the decade tells us that we must become like businesses. It tells us to import the planning, marketing, fiscal, management, and public relations technology from private industry. It tells us we have to make a profit even if we are not-for-profit organizations. That is the folk wisdom and all the soothsayers say that's what we have to do to survive.

While this wisdom has enhanced the development of more administratively and financially viable organizations, there is danger in this new orientation when the pendulum swings too far. The unspoken danger in this wisdom is the possibility that we could survive while losing our soul. Many organizations are being diverted from their historical mission while chasing this new business panacea. We need to redefine success, not in terms of bigger budgets and bigger buildings, but in terms of better service. If we are to compete, then let's talk in terms of recovery rates rather than occupancy rates. In retrospect, we may discover that many of the programs that had the power to make money in the 1980s did not have the power to change lives. Money has no utility within our field unless it is converted into resources that can change lives. Money must be the servant of our mission, not the mission itself.

© William L. White, 1993

Chasing the gods of growth and profit have been buttressed through our worship of regulatory compliance. External regulators define who we are, what we do, when we do it, under what circumstances, to whom, for how long, and at what cost. Many of our programs are chameleons whose color changes hour by hour depending on which regulatory site visit is occurring. This obsession with regulatory compliance weakens our fundamental character and induces passivity. It programs us to think of the regulators as the ultimate arbiter of quality services rather than the people who receive those services. It turns us from people changers into people processors. Treatment is measured not in terms of effects on the lives of our consumers, but in our ability to process them efficiently. We hire people with the skills and passion to help change lives and then drown them in paper and procedures. Progress becomes defined as a completed progress note—appropriately dated and signed with the right color ink—not progress reflected in the transformation of a client's life.

We have all been caught up in this process. As a program director in the 1980s there were many days as one survey team left and the next one arrived that I thought, "I could have a wonderful program here if I could just get rid of these clients." There were days I was tempted to get rid of those wild, free spirited counselors and hire a team of technical writers. Accreditation and program licensure should be seen as a baseline achievement, not the ultimate source of a program's character and identity. This baseline merely says that you have a body that has all the essential parts, but no accrediting or licensing agency can breathe life and power into that body.

The glorification of profit and regulatory compliance have created beautiful edifices devoid of substance. There are programs whose facilities are beautiful, whose program manuals are publishable, whose clinical records are unimpeachable, whose daily activities run like a well-oiled machine, but who do not have the power to incite and support the movement from addiction to recovery. Such programs have no passion, no commitment, no soul. Their commitment is not to a population of clients or to a professional field of service. Their commitment is to money—they have passion about addiction only to the extent that it exists as a billable diagnosis. To that goal—money—they have attained the highest evolution of efficiency as a people-processing institution. Clients aren't "in treatment" at these sites; clients "do treatment" like cons "do time." Professional helpers at these sites are turned into robo-counselors—super efficient processors. In such an organizational climate, clients and staff can

© William L. White, 1993

do treatment in a manner that does not require commitment or change from either. Prevention programs have not been immune from such influences. Prevention programs can get caught up in processing activities, rather than people, with a similar disregard for the effect of such effort.

As the period of highest profitability and popularity of the substance abuse field wanes, those institutional predators with veneer-thin commitment to our field will flee in great numbers. This is not, however, a simple story of good guys and bad guys. Even some of the best programs have felt themselves pulled into this people and activity processing mentality. Some of our best programs today have staff who report that in recent years something important has been lost in the life of the program. What is in jeopardy of being lost is the very heart and soul of the program: the passion and commitment to service.

D. Overextension of Technology

The fourth building block of our current crisis grew out of the over-extension of our prevention and treatment technology. We have developed over the last half century some wonderful assessment and treatment technology. There are hundreds of thousands of people in active recovery as a result of that technology. The problem is that our assessment and treatment technology is based almost exclusively on clients with very homogenous characteristics: white, middle and upper class males in their forties and fifties in late stages of gamma species alcoholism who present with minimal concurrent psychiatric impairment and who have minimal environmental obstacles to their recovery. Like compatibility between computer hardware and software, our assessment and treatment software works exceptionally well when applied to the client hardware for which it was developed. The problem comes when we interact this treatment software with clients with fundamentally different hardware. The result is often a shame-based treatment system. We place clients in treatment regimes that have little likelihood of success and then when they fail to respond to such treatment we blame them. We say: "You have to go back through the same 28 day program because you didn't do it right the last time."

The problem is not just that the treatment is unsuccessful. When we mismatch client hardware and treatment software, the client not only leaves treatment with their original problems intact but may have acquired additional problems as a direct consequence of the treatment experiences.

© William L. White, 1993

We call such consequences iatrogenic illnesses—they are treatment caused. Clients not responding to mainstream treatment often leave not only with their addiction intact but now have the added experience of treatment failure. Treatment failure may reduce the likelihood of future recovery through its enhancement of passivity, learned helplessness, learned hopelessness and dependence. Serious questions of financial exploitation and iatrogenic effects of treatment must be raised by the continual placement of relapsing clients in treatment modalities that have historically failed to provide a medium for movement into recovery.

In this period of explosive expansion of programs, we have over-extended our technology way beyond the populations for whom it was developed. There are special concerns about the iatrogenic effects of this misapplication to adolescents, the aging, women, people of color, persons with physical or psychiatric disabilities, and persons with enormous environmental obstacles to recovery, e.g., the homeless. Traditional treatment technology must be applied to new populations with great tentativeness and gentleness—not with the aggressive arrogance that has characterized our approaches to treatment by recipe. To the treatment fundamentalist who would rejoin that many adolescents, women, people of color, etc. have gotten sober through traditional treatment, I would suggest that many of these clients got well in spite of rather than because of our treatment technology.

We must disenthrall ourselves from narrowly prescribed treatment philosophies and techniques that have been elevated to the status of religious dogma and ritual. As we move into the nineties we must do two things. We must write prevention and treatment software that fits the needs and characteristics of subpopulations within an increasingly diverse culture. We must then institutionalize these new technologies by transferring them out of pilot and demonstration sites into the mainstream of substance abuse prevention and treatment. It's not enough that more than one thousand women in Illinois have been involved in the fourteen Project SAFE sites since 1986. The issue is how do we take the new knowledge acquired through Project SAFE and mainstream it so that women entering any substance abuse treatment program in Illinois will be benefitted by that new knowledge and technology.

We need new paradigms that don't destroy our older paradigms but embrace and extend them. The new paradigms must be broad enough to embrace multiple patterns of abuse and addiction which spring from multiple etiological pathways and which unfold in diverse familial and

© William L. White, 1993

cultural environments. The new paradigms must supplement our traditional rehabilitation technology with habilitation technology. The new paradigms in like manner must be able to envision, legitimize, and facilitate multiple pathways of long term recovery.

E. Service and Sacrifice as Pathology

The final building block in this crisis of values within our field involves changing judgements about the role of service within the field. This has involved two related processes: narcissistic inversion and the pathologization of commitment to service.

Working within human service disciplines has always been a medium through which persons could seek self-exploration and self-understanding. There is nothing inherently wrong with this practice, particularly when such benefits do not interfere with the quality of service to others. There can be an inversion process, however, whereby knowledge and skills intended to move outward to serve clients gets turned inward through an intense preoccupation with the personal and interpersonal problems of staff. Fueled by the narcissistic preoccupations of the whole culture in the most recent decades, this inversion process within human services has intensified resulting in a growing number of persons who use the field to receive rather than provide therapy. These narcissistic preoccupations have weakened the commitment to service.

Where narcissistic inversion would weaken commitment to service, the overextension of the concept of codependency would begin to define commitment to service as pathological. I am speaking of an era in which one's very choice of a helping profession was framed as pathology rather than virtue—was defined as a symptom subsumed under the newly created and ever-broadening disease of codependency. I am speaking of an era in which simple acts of courtesy and kindness to clients or to each other were met with the cryptic remark from another staff member: "How codependent of you!" Passionate commitment to service was something to hide, something to indicate one's untreated family of origin issues, something to be seen as the worst rather than the best within us. Staff who arrived in the field with great passion and ardor were suddenly confronted with a professional milieu in which such work-related fervor was stigmatized. Suddenly everything was pathology; everyone was pathological. A cartoon in one of our journals vividly illustrated this stance. The cartoon shows a huge auditorium with the banner "First Annual Convention of Adult Survivors of Normal Parents" and in this gigantic

© William L. White, 1993

auditorium sits one geeky-looking character in the front row. In an environment where one's own issues must be explored so relentlessly, service to clients becomes a troublesome and tiresome diversion from the primary mission of self-exploration.

If there is a challenge for our culture and our field in the 1990s, it is the rediscovery of the nobility of service to others. It is the rekindling of the kind of service and sacrifice that springs not from masochism or self-hatred but from the recognition of our connectedness to each other and from the recognition that the self is enriched through acts of service.

Many social commentators have suggested that individuals and countries should choose their enemies carefully because they are destined to become like them. Professional disciplines reflect this same process. Crime fighters are at high risk to commit crimes in the name of law and justice. In our own case, in fighting addiction, we have in the 1980s taken on dimensions of character that are the essence of addiction: narcissistic, grandiose, aggressive, rigid, exploitive, excessive, manipulative, and deceitful. Like the addict in crisis, it is time for self-inventory and self-renewal.

These five themes—rapid and turbulent change, competition and isolation, obsession with profit and regulatory compliance, technology over-extension, and the relabeling of commitment to service as pathology—are the seeds from which grew the current crisis of values within the substance abuse field.

IV. Strategies for Self-renewal

What is emerging out of this crisis is a period of self-inventory and self-renewal that is likely to extend through the 1990s. The 1990s within our culture and within our field are likely to parallel many aspects of the 1960s. There will be a serious and at times somewhat painful reevaluation of values and commitments.

Many programs of excellence have already begun this self-assessment and self-renewal process. They are charting the way for the rest of us. The directions which they point for our field—and

© William L. White, 1993

for our culture—involve a recrystallization of values and a recommitment to service. Six strategies seem to be emerging as vehicles to personally and collectively recenter ourselves.

A. Self-Inventory

The first strategy for self-renewal involves a process of self-inventory—a process whereby we step back from the image of ourselves projected in our press releases and conduct a sober inventory of our character strengths and deficits. The purpose of this strategy is to step back from the franticness and flurry of day-to-day service delivery to review where we are at as an organization and to determine if it is where we want to be, where we should be. It is to assess where we may have veered off course from our historical mission. The goal is not to shame the recent past. It is to see where we are at as an organization as part of a developmental process and to take control of the future direction of that development. Programs of excellence are conducting this inventory without blame or scapegoating, recognizing that progress is marked by an ebb and flow in which it is often hard to separate opportunity from diversion.

Programs of excellence are utilizing a variety of methods to conduct this self-inventory including informal discussions in staff meetings, formal planning meetings, board-staff retreats, internal staff surveys, client/community service satisfaction surveys, and assessments and interventions conducted by organizational development specialists. These approaches focus on listening to each program's individual and organizational clients as well as listening to the staff charged with serving those clients. Whether self-inventory is launched as a proactive process or in response to serious organizational problem, it is the beginning of self-renewal.

B. Organizational Renewal

The second renewal strategy being utilized by programs of excellence involves rebuilding the internal strength of the organization. If there is any message that collectively springs from the voices of front line workers it is the following: "We don't need bigger organizations, we need healthier organizations! We need organizational cultures that are congruent with the values of recovery." During the growth spree of the past decade the sheer pace of change often made it impossible to build in essential elements of healthy organizational structure and process. The self-inventory process quickly reveals such areas of neglect. Many programs of excellence are

© William L. White, 1993

taking the stance—or are being forced to by funding cutbacks—that the goal for the immediate future is no growth, that the focus must be on enhancing quality of existing programs before new services are initiated. A particular focus of organizational renewal is the enhancement of team performance through relationship-building across organizational units and increasing the scope and intensity of staff supports, such as clinical supervision and access to training. Conditions like role overload, role conflict, role ambiguity, role-person mismatch and other role stressors that emerged during the period of rapid change are diagnosed and reduced to the extent possible. Such developmental problems will not always be solved quickly but the crucial step is their identification as high priority agenda items to which staff time and emotional effort will be expended.

Programs of excellence are also exploring and celebrating what Tom Peters has referred to as "bureaucracy bashing." They are flattening organizational structures and decentralizing power and decision-making. They are culling out and joyously destroying artifacts of policy, procedure, structure, roles and, most importantly, forms and paper that no longer support their primary service mission. They are simplifying and streamlining and integrating and, in short, flushing the bureaucratic fat out of the institutional arteries.

C. Vision, Values and Ethics

The third renewal strategy being used by programs of excellence involves the development of a shared vision, shared values and an ethical foundation from which to redefine and re-energize the focus on service. Through exercises in strategic planning, on-going discussions about mission and philosophy, or efforts to develop codes of ethics and codes of professional practice, programs of excellence are struggling to wrest control back that has been abdicated to external forces and redefine their mission and their character. Programs of excellence, by recentering themselves, are using the technology of business to support their mission rather than letting business become their mission. They are doing this by filtering decisions related to the business of the organization through the newly focused values and mission of the organization.

This assertion of the importance of mission and values harks back to a parallel period in the historical evolution of Alcoholics Anonymous. AA went through a turbulent period in the 1940s shaping the traditions that would govern the group life of the fellowship. The need for such focusing came about as a result of explosive growth and visibility, in short, from AA's success.

© William L. White, 1993

What came out of this internal soul-searching within AA was an understanding that would profoundly influence what became the 12 traditions. That understanding was a recognition that money, power, politics and property separately and collectively had the potential to divert AA from its single mission—carrying the message of recovery to the still suffering alcoholic. Fifty years later, programs of excellence are learning the same lesson. Like AA in the forties, programs of excellence are crystallizing the values that will govern their group life and guide their delivery of substance abuse prevention and treatment services.

A growing number of programs of excellence are also attempting to cultivate spirituality as a source of organizational renewal and empowerment. To speak of spirituality in an organizational context does not rely on the religious or the mystical. It simply says that there are resources and relationships outside the organization that can empower and imbue hope. It simply says that a commitment to service brings duties and responsibilities that transcend individual and institutional self-interest. Spirituality as an organizational concept recognizes our essential connectedness to one another and that this connectedness can be experienced through acts of service. Spirituality as an organizational concept recognizes that the great issues of our day are played out in microcosm in our daily lives, and that it is through our individual and collective actions—reaching out beyond our self-interest to discover mutual interests—that we change the world. Spirituality is igniting and nurturing hope within the organization and the transmission of that message of hope into the world.

D. Commitment: The Rediscovery of Professional Passion

The fourth renewal strategy being used by programs of excellence involves re-igniting passion, enthusiasm, and commitment to this vision of service. Programs of excellence recognize the critical role staff energy and emotion play in the process of client empowerment. Deeply imbedded, self-defeating patterns of passivity, helplessness, hopelessness and dependence in the lives of our clients can't be challenged by staff who are emotionally uninvolved or convey feelings of futility, boredom, frustration, or hostility to their clients. Programs of excellence are recognizing that change is something many clients will get caught up in rather than consciously choose—more a serendipitous adventure that they wandered into rather than a premeditated course of action. Such programs recognize that it is our passion and energy that must ignite the earliest stages of the change process. Our energy is the battery that can be used

© William L. White, 1993

to jump start other people's lives. It is the passion of our involvement that allows us to perform this kind of psychological resuscitation. In the face of client hopelessness, it is our hope that must open up new possibilities. In the face of helplessness and passivity, it is our faith and energy that will empower the client's will to act.

Programs of excellence are casting off the mantel of pathology attached to service and once again celebrating the nobility of what we do. Programs of excellence are re-elevating persons to the status of organizational heroes and heroines who view service in terms of privilege rather than pathology, who don't see personal happiness and fulfillment incompatible with social duty and public service. Programs of excellence are building in affirmations and rituals to nurture personal and institutional commitments and to explore the actions that embody such commitments.

Programs of excellence are re-asserting that their commitment is to the service of people, not to particular ideas or paradigms. The commitment is to assess and respond to the needs of their clients and their communities with all of the resources they can command. This commitment means that the needs of their constituents define the models of service, not vice versa.

Many programs of excellence are also reaffirming that this commitment to service must embrace the disempowered. It must embrace clients of different sexes and sexual preferences. It must encompass all ages and cross generations. It must embrace people of color and communities of color. It must embrace addicts within the criminal justice system. It must embrace addicts who have significant and special obstacles to recovery whether the obstacle is HIV, psychiatric illness or homelessness. It must embrace the full spectrum of alcoholics and addicts, including those without power and influence (and insurance). The commitment must be inclusive rather than exclusive.

E. Community Building and Consensus Building

The fifth renewal strategy being utilized by programs of excellence involves rebuilding relationships with other agencies and individuals in the professional community and rebuilding relationships with community institutions. The purpose of this reaching out is not public relations or marketing, but listening and relationship-building. It is an attempt to rejuvenate our

© William L. White, 1993

own organizations through the injection of new ideas and perspectives. It is a genuine attempt to seek out the needs and resources within a community. It is an attempt to reach other persons with shared concerns. It is an attempt to link our own vision with that of kindred spirits. It is an attempt to link resources to increase our power to effect positive change in individuals and in the environments they inhabit.

Programs of excellence are recognizing that we must stop building walls and begin building bridges to link us with other health and human service disciplines. More and more programs are beginning to move back into the life of their professional communities. They are seeing themselves as part of that professional community and are assuming the duties and responsibilities that come with such membership. They are modeling not only a cross-fertilization of technology but a cross-fertilization of spirits, a mutuality of support among healers and change agents. Given the growing numbers of clients who present with multiple problems and problems with such great chronicity and intensity, programs of excellence are beginning to forge multi-disciplinary, multi-agency assessment and intervention models. They are declaring through their actions that the competition-driven isolation of the 1980s must give way to cooperation and collaboration as we move into the next century.

Programs of excellence are getting out of their buildings and into the life of the communities we serve. They are moving into the schools, and the churches and the neighborhood centers. They are regenerating the tentacles that once extended from their organizations deep into the heart of their communities. They are renewing an emphasis on service delivery in the client's home environment. They see themselves as organizers involved in building a vibrant culture of recovery within their local communities—a culture of recovery that can both attract and support their clients.

F. Social Action

The final strategy of organizational renewal is to break out of the institutionalized cowardice of the 1980s—a time when social conscience was abdicated and exchanged for personal and institutional self-interest. For the past decade, IADDA has often been a lone voice raising public policy issues that transcended our isolated interests as local programs. IADDA is being joined by a growing number of individuals and programs calling for a renewed activism. Renewal

© William L. White, 1993

through social action involves two dimensions: 1) confronting abuses within our own field that jeopardize the future accessibility, affordability and credibility of substance abuse prevention and treatment services, and 2) confronting the political, economic, and social conditions within which substance abuse is embedded.

In the first of these strategies we must in our organizations, professional associations and advocacy groups begin to define standards of professional and ethical conduct that will govern our business and clinical practices. We must confront the fact that external regulatory and fiscal controls that are compromising the availability and range of addiction treatment services emerged, in part, from exploitive practices within our own programs. We must begin to re-establish integrity to our clinical and business practices before reimbursable services for addiction treatment once again disappear from our health care system. That integrity must come from internal standards development and internal policing. It was as much the silence of the majority as it was the exploitive abuse of the minority that led to the external regulation of our field. We must elevate the level of our ethical standards and hold each other accountable to such standards.

If in our inventory of ourselves and our environment, we have our consciences pricked or punctured by conditions that promote addiction within our society, then we must cry out against such conditions. Our mission of service to the individual addict cannot be abandoned, nor can we let social or political action divert us from our primary task. Our continued silence, however, is unconscionable. We must add our personal and institutional voices to confront any economic, political or social pathologies that help initiate or sustain the personal pathology of addiction. To the extent that racism, sexism, homophobia and other exploitive and self-obliterating "isms" play a role in the etiology of addiction or constitute obstacles to recovery, they must become our issues. To the extent that poverty, homelessness, inadequate child care, inadequate health care or any other issues pose obstacles to initiating and sustaining recovery, they must become our issues.

There is another important and politically dangerous issue that we must face. To the extent that forces of drug promotion operate unchecked in our communities, this must become our issue. We must begin to confront the contradictions raised by the massive promotion of licit drugs in this culture. Those of us on the treatment side of our field must begin to add our voices to the

© William L. White, 1993

growing numbers of prevention professionals who are beginning to confront the massive promotion of tobacco, alcohol and other licit drugs to our citizenry. The practice of targeting—developing special products and promotional campaigns aimed at particular populations such as youth, women, people of color, the alcohol and drug dependent—is particularly offensive and must be confronted. As organized efforts and acts of civil disobedience to challenge such predatory drug promotion increase, it will be interesting to see where we as a field cast our lot. Will we help support or provide leadership to this movement? Will we be participants in this movement along side our community constituents? Or will we be bystanders, noticeable by our absence and our silence? If it is the latter, then we will deserve being called parasites and predators for our abdication of courage and conscience.

The revival of social action by programs of excellence is based on a disturbing self-realization—the realization that we are either agents of social change—instruments to alter the economic political and social structures that breed or exacerbate personal pathology—or we are parasites who feed on the problems of our clients and our communities to support our own material and emotional comfort. As substance abuse prevention and treatment professionals, we draw our sustenance from the addict's pain in no less measure than the drug dealer. Our homes, our cars, our clothes, our lifestyles—whether dealer or counselor, whether liquor wholesaler or nurse—are sustained by addiction. So what separates servant from predator? Predators have a vested interest in both sustaining the person-drug relationship and sustaining the social conditions that make that relationship so seductive and enduring. Servants seek to break the person-drug relationship *and* attack conditions that support this relationship. Predators peddle chains and justify or are silent on the issue of slavery. Servants break chains *and* attack the institution of slavery. It will be important for each organization in the 1990s to figure out if their essential character more closely resembles the predator or the servant?

IV. Closing

I have tried to define what I consider to be a spiritual crisis spawned by many forces which have worked to divert us from our primary task. Our ability to confront such diversions and get refocused on our primary service mission is crucial for the renewal of the field. In the lexicon of the civil rights movement, we must keep our eyes on the prize. When you strip away all the

© William L. White, 1993

buildings and budgets, the policies and procedures, and the administrative and supervisory supports, the impact of the whole field comes down to the point of interaction between front line workers and our service consumers—whether they be citizens or clients. It is the transforming power of that point of contact that must be our perpetual focus. That's where the action's at. Everything else is secondary.

If there is any message that emerges from our history it is that individuals and individual programs of excellence can have a profound effect on the evolution and advancement of our field. Having that kind of effect requires both technical knowledge and skills and a passionate commitment to service. You will have great opportunity to seek out new knowledge as this conference proceeds. As you seek to enhance your technical knowledge, I would also charge you to seek out opportunities to refocus your professional values and commitments, to recapture that spirit of service that first drew you to this work.

I hope the re-emergence of service as the centerpiece of our field will be paralleled by similar processes of renewal in other health and human service disciplines. Perhaps even more importantly, I hope it is part of a broader process of cultural renewal through which we break out of the isolation and alienation of the past two decades and rediscover the values of social duty and public service and regenerate our connectedness to one another and our sense of community. I hope you and I can look back in the future and feel we were leaders in this broader professional and cultural movement.

I would like to leave you with these thoughts. There is no profession potentially more honorable and more fulfilling than our own. There is nothing more noble than promoting the health of individuals, families and communities. There is nothing more heroic than participating in the life-enriching transformation of another human being. We have the power through our prevention and treatment technologies to intersect with human beings and forever alter the trajectory of their lives. *If there are heroes and heroines in our culture right now, they're not on Wallstreet, they're in this room, and they're working today in the programs which each of you represents!*

© William L. White, 1993

ABOUT THE AUTHOR

William L. White, M.A.— Bill White has a Masters degree in Psychology and 27 years of experience in the health and human service field as a clinician, clinical director, administrator, researcher and well traveled trainer and consultant. He is currently a Senior Research Consultant at the Lighthouse Institute, a division of Chestnut Health Systems in Bloomington, Illinois. Bill spends more than 125 days each year providing training and consultation services to a wide variety of organizations throughout the country.

THE LIGHTHOUSE INSTITUTE

The Lighthouse Institute, a division of Chestnut Health Systems, offers advanced technical education and training for health and human service organizations and a wide variety of management training, consultation and research services available to organizations throughout the United States. The Institute also publishes books, curricula, and monographs on topics of high interest to its clients.

© William L. White, 1993



Lighthouse Institute

A Division of

Chestnut Health Systems

Workshop/Publication Mailing List

If you are interested in receiving announcements of LTI workshops and publications, please complete this card and return to:

Lighthouse Institute, 702 W. Chestnut St., Bloomington, IL 61701

Please Print

Name _____

Position _____

Agency _____

Bus. Address _____

Home Address _____

City _____

State _____ Zip _____

This is my ☐ business ☐ residential address.

Please check areas of interest:

☐ Aids	☐ Domestic Violence	☐ Special Populations
☐ Child Welfare	☐ Mental Health	☐ Substance Abuse
☐ Criminal Justice	☐ Program Management	☐ Supervision

☐ Other _____

Mailcard/White6



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: Bill Moyers interviewing Bill White (1998). Posted at **www.williamwhitepapers.com**

Bill Moyers Interview with Bill White, Spring, 1998E

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The following is the editing transcript of an interview by Bill Moyers with Bill White on the policies and realities of drug enforcement and treatment. White is a Senior Research Consultant at Chestnut Health Systems in Bloomington, Illinois. Portions of this interview appear in the CLOSE TO HOME television series that first aired in March, 1998.

***Moyers**:* How do you see addiction? Do you see it as a biological disorder, a psychological distress, or environmental conditioning?

***White**:* The history of addiction science is a history of everybody trying to find the one key thing which defines addiction, the one and only cause. In my own career over about three decades, you could probably plot how I've progressed from very narrow models to very expansive ones. Because addiction presents itself with very homogenous characteristics, people believed it would only respond to a very narrow treatment approach and that there was only one legitimate way to recover. And there were many different schools of thought about what that one true way was. Where we have painfully matured to as a field is a place where we recognize that addiction is in fact multiple disorders. There are multiple causes of addiction. They present themselves in very diverse patterns and characteristics. And the treatment for the varying types needs to be very, very different. Even the prevention strategies for those different subgroups need to be very different, and there are countless ways to recover.

***Moyers**:* So addiction is not any one thing? It's not enough to know that someone is addicted if you want to help him?

***White**:* We can say that addicts all share in common some problems in their life related to their relationship to alcohol or other drugs, but the nature of those problems and how those problems develop may be very, very different, and resolving those problems may require some very different strategies.

***Moyers**:* What did you mean when you wrote that for an addict, it's as if he wandered into a magical world?

White: We tend to think of addiction as a relationship between a drug and person, but we often forget that there's an entire, elaborate social world that surrounds that person/drug relationship and for some people that world can be as addictive as the substance itself.

***Moyers**:* What do you mean?

***White**:* It's a world with its own language and value and rituals. A world where whole ranges of human needs can be met. To let go of the drug is not just to let go of a chemical relationship, but also a connection with an entire social world.

Moyers: The people, places, and things that we talk about.

White: Absolutely. And it's not just the drug that leaves a vacuum, but it's the entire social network. If I've been immersed in what I call cultures of addiction and suddenly I leave this residential program, I have committed myself to recovery, but now what do I do? It's Saturday morning, I just got home from treatment. Every relationship, every place, every thing, every word out of mouth in my home community ties me to relapse -- to returning to my addictive lifestyle. I've got to replace not only the hole inside myself that that drug filled, but I've got to create an entirely new set of friendships and relationships.

Moyers: So addiction is a way of life.

White: Yes. And giving it up requires a huge change.

Moyers: What do you mean when you say that alcohol is a celebrated drug in our culture?

White: These are drugs in a culture which are almost synonymous with the culture. It's practically unpatriotic not to use them. We ritualize their use. We promote them. We subsidize them. One of the things we do with these drugs as well is that we don't define them as drugs.

***Moyers**:* Only recently did the FDA win the right to classify tobacco as a drug. And we talk about "alcohol and drugs," because otherwise people wouldn't think alcohol was included.

***White**:* Yes. Our historical, celebrated drugs have been alcohol and tobacco and caffeine, even though we've played out ambivalence, particularly with tobacco and alcohol. It's interesting right now, because we're in a transition. In the last 30 years, tobacco has been moving from being a celebrated drug toward becoming a highly stigmatized drug choice in America. As a result, we're actually beginning to see what some people might call "dope fiend behavior" by smokers as they band together and create a deviant subculture to support their use. Watch smokers huddled outside an office building in the snow to see what I mean. Thirty years ago there was no need for deviance, because the culture itself celebrated this drug and made it very easy for those of us who were addicted to tobacco to use it.

Moyers: Do you think it's hypocritical that we celebrate alcohol and denigrate the opiates like heroin, or does that make sense to you?

White: If you're asking me if it makes any rational sense, you would be hard-pressed to build the case why in certain cultures opiates are celebrated and in other cultures alcohol is celebrated. I would suggest that it has little to do with science or pharmacology in either culture. It has much more to do with the historical niche that a drug fills within that culture. Most importantly, drug policy depends on whom we associate with that drug. We almost always confuse our feelings about drugs with our feelings about the people we believe to use those drugs.

Moyers: What do you mean?

White: One example would be if one culture conquers or colonized another. The first thing the dominant culture will do is destroy the celebrated drugs of the vanquished. Part of colonization is implanting our celebrated

drugs in their place. It's part of the destruction of the native culture. It's not about science or public health or which drugs are harmful. It's about dominance. So in the '60s, when an 18-year-old made a choice between smoking pot or drinking martinis, it had little to do with science, but in fact was a political act. Our reaction to those drug choices has as much to do with the symbolism involved in them as with the potential harm which could result. I'm sure you remember a time when parents were relieved when their children drank alcohol, rather than taking illegal drugs. Now in retrospect, we know that an awful lot of young people got in trouble with alcohol in the '60s and '70s when we lowered the drinking age, but it's understandable in light of those categories.

Moyers: I remember a time when parents put candy cigarettes in the children's stockings at Christmas.

White: Yes. Part of what we do with celebrated drugs is we teach children rituals to allow them to practice use. We not only had candy cigarettes, but how many kids didn't practice acting drunk and drinking growing up? I mean you know exactly what the doses, what the brands are. Candy cigarettes are to smoking what training wheels are to bicycling.

Moyers: Is it also because it takes longer for alcohol and tobacco to work their harm, whereas opiates can act much faster in creating anti-social and individually destructive behavior?

White: Medically, the dilemma we have is that alcohol and tobacco are both related to chronic diseases. It takes large lifetime doses to produce many of the most devastating consequences. Now, that's not true for alcohol in terms of consequences like accidents or fights, but in terms of liver disease or brain damage it is. With the opiates, while overdose tends to kill young people, chronic use itself is actually not associated with medical problems, and we don't know what percentage of overdoses are a result of poor knowledge of drug content because illegal drugs aren't labeled for purity. Anti-social behavior tends to have to do more with who the user of the drug is, so you don't see rich heroin addicts, for example, mugging old ladies.

Moyers: How, then, were our drug laws developed?

White: They grew out of racial and class struggles, particularly on the West Coast and in the South. The first state laws were based on this sort of "dope fiend" caricature -- showing somebody of a different race and a different culture. In California, it was Chinese railway workers smoking opium; in the South, it was black men using cocaine. The reality is that the vast majority of people addicted to narcotics in the late 19th century were white affluent women, who were primarily addicted through traditional medicine or over-the-counter "patent" medicines. The caricature which drove the prohibition campaigns in the late 19th century bore little resemblance to reality. And, to give you a modern version of that, in the mid-1980s, when cocaine was overwhelmingly a white phenomenon in America, the images which began to appear on television were overwhelmingly of African-Americans, particularly young African-Americans enjoying crack cocaine on a street corner. If you look at all the exposes of drug exposed infants, we see young African-American infants, trembling in neonatal intensive care units. But that image was not the reality of cocaine addiction in the United States in 1985.

Moyers: Why?

White: At that exact point in time, those who were addicted to this drug were overwhelmingly white and affluent. The best predictors of cocaine use at that point were education and income. As years of education went up and annual income went up, the probable use of cocaine went up. Yet the image was and still is that we have poor inner-city African-Americans involved in all of these criminal illegal markets. Much of the

anti-coke rhetoric and the changing of laws it generated was based on that early image. But in 1985, it had little relationship with reality.

Moyers: I grew up on the Red River between Oklahoma and Texas, and at that time 45 years ago we had an expression "drunk as an Indian." Is this the same sort of racist stereotyping?

White: Yes, and what's fascinating is that in the last 20 years, there have been several studies which have forced us to completely rethink our understanding of the initial contact between Native Americans and alcohol. That research shows that at the very earliest contact, not only were native people not particularly vulnerable, many of them were not attracted to this drug at all. And many who were exposed to that drug did not exhibit the kind of drunken mayhem which came to be the drunken Indian stereotype. In retrospect, the image of the drunken Indian -- particularly in our early history -- may have very much been part of an overall effort to devalue native people and provide one more justification for the notion of manifest destiny, which said it is our right to sweep from coast to coast and destroy these native cultures.

Moyers: What do you think this kind of caricaturing does to our drug policy and to our ability as a society to come grips with addiction?

White: What it's done for a long time -- both our image of drug addicts and also the traditional stereotype of the skid row alcoholic -- is to almost guarantee that there would not be a public health response to this problem. When we create images that do not engender empathy in most people, then our policy is going to be to isolate and sequester and punish those individuals for their deviance. We end up criminalizing as opposed to medicalizing the problem. We talked earlier about celebrated drugs. What our image of addicts and alcoholics also does is to help people addicted to legal substances avoid facing their problems. As a society, we push these drugs very, very hard, and suddenly somebody close to us is struck by this disorder. It becomes almost unthinkable that a "nice middle-class white person" could be an alcoholic. I remember in my early years working in treatment a vivid image of a family bringing their mother in. Superficially, she looked like she just stepped out of Vogue -- until we began to get her medical reports back. This woman had the highest liver profiles I've ever seen -- she had advanced liver disorder. This woman never took another drink in her life but she died anyway. Now what she died of was alcoholism, but she also died of a myth. The myth was she can't be an alcoholic because she's a woman and even more than that, she's a beautiful, well-dressed, middle-class woman. It was very much apart of her defense structure to keep herself beautiful, because if she was beautiful she couldn't possibly be a drunken bum.

Moyers: Who are the women you work with in Project Safe?

White: Very different women from the one I just described. The majority of Project Safe women have extensive histories of substance use and domestic violence. They come to our attention because they have been abusing their children and have either lost custody of them or are in danger of having them taken by the state. These are poor women, with many, many problems. Some of those problems have been carried down from generation to generation. If you were going to describe a client that has little probability of making it through treatment, I would describe the typical Project Safe woman. They have incredible risk factors both in terms of their own characteristics and in terms of the drug-filled environments in which they live.

Moyers: What determines whether someone is at high risk for addiction?

White: There are a number of sub-populations of individuals who are at high risk. Family history is one factor. Over 74% of Project Safe women have alcoholism or addiction in their families of origin. We know

that individuals are at higher risk if they have particular psychiatric disorders. The majority of our women have prior psychiatric histories involving depression or borderline personality disorder. And there's another important category of risk. Large numbers of these women -- in fact, between 65 and 95% of them -- have extensive histories of sexual victimization and severe abuse or neglect during their childhood.

Moyers: I've read studies which find that between 75-80% of women who come for addiction treatment were sexually abused.

White: Yes. In fact, we've looked at that somewhat closely. It's not simply that sexual abuse increases the risk of substance abuse. We have a lot of people in this culture who were physically and sexually abused as children who grow up without becoming addicted. But with these clients, it's not just the fact that they were abused, it's the intensity and duration of the trauma that increases risk. When we compared their victimization to that of other people who had been abused but not become addicted, what we found was the following: our women were abused at a younger age, the abuse lasted longer, often for many years. It frequently involved multiple perpetrators. It almost always involved perpetrators from the family, which means a greater violation of trust. Also, they grow silent about this because when they've told somebody -- and all of them told at least one person -- they either weren't believed or they were believed and then blamed for what had happened. Most importantly, after they told someone, the abuse did not stop. In fact, in many cases, it even escalated. And the abuse was more invasive. An example would be if someone exposed themselves to me at age seven, I would be sexually abused by any definition, and the same would be true if someone sodomized me, but the latter is a much more boundary-invasive form of sexual abuse.

Moyers: So you mean there were particular patterns of abuse which were linked with increased risk for addiction?

White: Yes. The intensity and duration of childhood victimization dramatically elevated risk for adult substance use patterns. The more severe and prolonged the abuse, the greater the likelihood of addiction.

Moyers: What does that tell you about addiction?

White: That trauma to children is at least one category of elevated risk. If we were going to talk about prevention, one of the things that we could do was find ways to saturate resources to stop the abandonment and brutalization and victimization of children. With women, particularly, it seems as though that would make a huge difference.

Moyers: And what would you do about the high-risk kids who come out of the alcoholic womb or the alcoholic father?

White: I think the same ideas we've developed for treatment apply for prevention. If we have multiple sub-populations, we need multiple interventions that maybe look very different from each other. I don't think there's ever going to be a generic prevention that's effective, because the sub-populations are so different. In fact, there is a danger of iatrogenic effects -- unintended harm which results from efforts which might work to reduce substance use in say, 90% of the population, but can actually increase the risk in 10% of the population. We know that some early substance abuse prevention programs actually incited experimentation. The levels of use went up as a result of what we did in the name of prevention. In terms of sub-populations, if we know that there are multiple sub-populations, then probably what we need is a menu of prevention strategies specific to addiction. Not alcohol or drug use, but addiction prevention, specifically focused on those target populations.

Moyers: So what does your research tell you about why people who have been abused turn to drugs? What does the drug do for them? Does it medicate the pain?

White: I wish I could say it was one thing, but it's probably a combination, and there's clearly a role for anesthesia there. When our women get into situations of emotional crisis, it reactivates much of that historical pain related to victimization in their childhood. Their response is often to reach out and self-medicate that, but they can do other things as well. Some of these women are as addicted to crisis as they are to the drugs. Intervening with them is like intervening in a hurricane. There is just so much going on, and what creating crises does is exactly what the drug does. It offers another way to defocus.

Moyers: Defocus?

White: Yes. When I'm beginning to experience emotional pain related to abuse, all I've got to do is create a crisis in my environment and suddenly I'm pulled out of myself into a dramatic and distracting situation.

Moyers: So what do they do? How do they create a crisis?

White: Well, if we took 100 women with that developmental history to age 22, do you have any idea what their intimate relationships might look like? These women have an incredible capacity to involve themselves in destructive intimate relationships. One of the clients that I interviewed not too long ago, I've asked her many times, "Of all the things you've been through now in almost nine years clean, what's the most difficult?" Early on, she had told me that not using cocaine was the hardest thing for her. This last year, I asked her again, and she said, "In the long run, I think it's been this thing about losers," and she began to describe to me this long, long series of very destructive intimate relationships. Not while she was addicted, but during her early years of recovery. The only good news was that each one got a little less toxic. I asked her, "What sense have you made out of that for yourself?" and I'll never forget what she said. She got this sort of pensive look on her face and said, "What I understand today is if I'm attracted to them, they're high risk," and what she meant is that when she walks into a room and feels powerful attraction to a man or a woman, it is not what your friend Joseph Campbell called the "zeal of the organs" for one another. It is not healthy sexuality for her -- it is like a very destructive drug choice. Because, due to her background, a man whom she feels "chemistry" with is almost bound to be abusive.

Moyers: So in her case the alcohol and cocaine were just satellites of a deeper disorder that she had to deal with?

White: Yes. Even though, over time, alcohol and drugs may have taken on a very primary role in her life and may need to be treated as a primary disorder, if we look at the etiology -- how did this woman become addicted? -- we need to go back to that notion that there are many different pathways to addiction. For her, as we look at the trauma in her life, she may have reached out to drugs for a number of reasons. It might have been for anesthesia; it could have been part of her incredible impulsivity; it could have been part of her propensity for risk-taking; it could be the fact that she has great difficulty initiating and sustaining personal relationships. In fact, the drug may be the most consistent relationship she's got.

Moyers: Given all of that, for these women, what could possibly bring about change?

White: It's a fascinating question, and what we learned was surprising to me after spending two decades in the field. When I began to evaluate this project in 1986, what I expected is what I always expected -- I'm waiting for a crisis that's going to be the point of transformation. The classic hit-bottom ping!, and then out of that comes an opportunity for change. We didn't have that in Project Safe. I kept going back and interviewing clients and interviewing outreach workers, and what they told me was not at all what I thought I would hear. I had outreach workers saying, "You don't

understand, my clients don't hit bottom, they live on the bottom. Bottom is not new for them." What they said is -- think again in terms of histories of victimization -- these women's capacity for physical and psychological pain is almost limitless. If we wait for them to hit bottom they will die. The issue is not an absence of pain in their lives. They've got more pain than most of us can even comprehend. The issue is an absence of hope. Now, that's a radical rethinking of how people are motivated to enter into the recovery process.
In my field, historically, we said, "Number one, you've got to hit bottom, got to feel that the drugs now bring more pain than pleasure. Until that happens," we said, "there's nothing we can do."

The next stage, historically, was that we said the only reason it takes so long for people to recover is that alcoholics and addicts manipulate these "enablers" -- their families and friends -- to protect them from those consequences. So we decided to educate the enablers so that the alcoholic or addict would hit bottom quicker. The third stage was the idea that we can bring the bottom up -- and we began with both workplace interventions and family interventions. We began to stage these loving confrontations, and we found that it worked. We staged those interventions for the most part in the 1970s and '80s on culturally empowered white alcoholic men, and sometimes on their wives. It was amazing technology. We would have those people in treatment within 72 hours. But we never asked, "What happens when you do that loving confrontation to someone who brings no hope to that experience?" What we had in Project Safe was a very, very different group of people. The men in the 1980s had experienced hope because as white men in this culture they had been given a gift, the experience of power. They had been able to make decisions which affected their personal destinies, and in fact, as they began to deteriorate in their addictions, they often responded with grandiosity and narcissism. Some of them would be dying of alcoholism, and they still thought they were going to pull this thing off by sheer will. But the Project Safe women didn't have that grandiosity or arrogance, so programs designed to confront it and make them feel powerless merely reinforced their negative self-images.

Moyers: White men who recovered had other things to live for?

White: Yes. They had pre-existing foundations of family and skills and levels of achievement. Some may have lost jobs, but they still had a core belief that they could make it. In contrast, we found with Project Safe that if you escalate pain where there's no pre-existing foundation of hope, not only do you not spark this wonderful transformative experience, what you actually do is increase the risk of self-destructive behavior and flight.

Moyers: What do you mean if you increase pain? You mean if you take away their drugs, if you take away their culture of addiction?

White: No, I mean threats by Child Protective Services like taking away their children, for one. The assumption we have is that this threat gives us enormous power. They will say, "Oh my gosh, where's treatment? Let me get there right now." But what we found was when we knocked on doors and threatened to take the children, women said, "Which one do you want or do you want them all?" What we thought was our great power to coerce based on threatening pain, when you think of the amount of pain in their lives, was not significant. They didn't feel they could do anything to avoid the pain, so it didn't give us any power over them. Later, I'm interviewing women who are doing incredibly, who have turned around their lives and their families, and I'm asking, "Can you describe to me how you got started in treatment?" and I'm waiting to hear the crisis, and the escalation of pain, and it's not there.

Moyers: What had happened? Had they actually hit bottom?

White: I didn't hear "I hit bottom" stories. What I heard were stories like this. One woman said, "It's that outreach worker. I couldn't get rid of her." She told me, "The second time she came she caught me at a weak moment," and what she meant was at that time this woman, in a moment of vulnerability began to reveal an enormous amount about her life, and began to disclose herself as a person.

Moyers: To the person who had knocked on the door?

White: Yes. Now you would think this is a great breakthrough and we're going to get this woman to treatment the next day. In reality, the outreach worker couldn't find the woman for three weeks, because behind that self-disclosure she had panicked and taken flight. But the outreach worker kept coming, and the client would later say to me, "My babies had already been taken. I was out in The Life, running the streets, I was stopping back to my place for clothes, and, I swear to God, every time I stopped by my place, that woman was waiting for me or there was a note on my door from her."
So I asked her to describe the day she finally went to treatment, because I'm still expecting a crisis or some defining moment, but she said, "It was like a hundred other days; I stopped by to pick up clothes. There's a knock on the door, I open the door, and here's this woman one more time, and I looked at that woman and said, 'Don't say a word. Let's go.'" Now what happened here? There's no pain and there is no crisis. What happened from the time the outreach worker first knocked on her door several months later when the woman agreed to go to treatment?

Moyers: Was it that she developed hope? How can hope spur recovery?

White: At the point when the pain of late-stage addiction is experienced acutely, without hope, you will get suicide. We may not even know that it's suicide, but what we will see is death in the face of incredible pain. The essence of recovery is a collision between that experience of pain and consequences and simultaneously an experience of hope that there is a different way, some other life, not the same old drinking and drugging.
It can happen in many ways. The collision could come together like in the Bill Wilson story in 1934 at Charles Town's hospital. A late-stage alcoholic admitted for the third or fourth time, Bill Wilson suddenly, in his desperation, screams out, "If there's a God let him show himself," and experiences a profound spiritual awakening. We can say from that moment forward he is a person in stable recovery who will go on to be one of the co-founders of Alcoholics Anonymous. That blinding conversion experience is just one example. But if we only have the pain without the hope, we might have had a suicide in that hospital, or Bill Wilson might have gotten out of his bed and gone to a bar. So what our outreach workers bring to the Project Safe women is not a message about pain and consequences. They bring hope, they just kept saying it could be different, it can be different. You can do it, you are worthwhile. They slowly build a relationship and penetrate all that distress and all that fear and out of that relationship come some sparks that say maybe it can be different.

Moyers: Once they get to treatment, what are the techniques of change that produce hope?

White: Well, first, we needed to redefine it for these women, because again, it was designed for empowered white men. For them, once you overcome the arrogance and denial, there's usually a breakthrough and then they do treatment very well. There may be relapse issues down the road, but they do well in treatment. But our women didn't know how to play the client role quite as graciously as our traditional clients. They wanted to keep coming to treatment, but they also wanted to keep using cocaine. Or they would come into treatment one afternoon, blow up in a group and shout profanities at everybody, storm out of the place, and call back two hours later wanting to make sure it was still OK to come back tomorrow. We

would have a woman that we were putting through parenting training, and she would just walk out of the parenting class and go downstairs to the childcare that we had to pick her children up. The child would go running the opposite direction, and this woman, in maybe her second or third parenting class, would put her hands on her hips and bellow, "Jeremy, if you don't get back here right now, I'm going to whip your ass." But then she'd get this pained look on her face and say, "But I'm going to talk to you first." All of those behaviors began to teach us that we're not going to have conversions here. We're going to have destructive and very fragile healthy behaviors existing side by side. Our only goal is each day we've got to get the destructive side weaker and the healthy side stronger, but we've got to tolerate this stage of boundary testing. We almost call it pre-treatment. Many of our clients needed a sort of grace period, where they could learn the rules.

Moyers: I want to understand how allowing that kind of flexibility -- they're still using, they're not following the rules -- could help someone overcome a serious addiction?

White: Well, traditionally what we would do, and I know it sounds irrational, but we would say, "If you're coming into treatment, what we're asking you to do is to give up the primary symptom of what we call your disease, and if you exhibit that symptom then we're going to throw you out." Think about the logic involved in that! We're saying that this person has a disease characterized by their inability to control their drug use. Because of that, they come into treatment. They then exhibit immediately a symptom of the disease which ought to convince us they need to be here, but historically, we expelled them instead. What I'm suggesting with these women is that if we took that traditional approach, the vast majority would have been discharged from treatment in the first seven to ten days. Not only would they not have completed treatment, the vast majority would not have even started. We had to rethink our goals. Instead of requiring people to come in motivated, we decided that achieving motivation for abstinence, not just teaching abstinence skills, are appropriate goals for treatment.

Moyers: So what do you do about motivation? How do you create motivation where for years there was none?

White: We needed to show them that there was hope, that women just like them could and have recovered. Many of our outreach workers are former clients, and in treatment we continue to expose them to other similar women who have gotten better.

Moyers: So they can see an example: Six weeks from now I could be like that.

White: Yes. Especially because the first thing a client is going to say is, "But you don't understand, you've never -- ." All of our role models can say, "Oh yeah?"

Moyers: Been there, done that.

White: Been there, done that more times than you have, in many cases. It wasn't the threats which provided the major incentive, it was these powerful, powerful issues related to hope that begin to move the process.

Moyers: But the tone of the earlier abuse is still there. The sexual abuse is still there. The poverty is still there.

White: Which makes the early stages even more difficult and crucial. If I've got somebody who their whole life has been either victimized or abandoned by everyone close to them, imagine the difficulties when I knock on the door and say, "I work for the government; I'm here to help you."

Moyers: What's your measure of success?

White: We used many. We looked very concretely at issues of substance use, pre- and post-treatment. We looked at emotional health of the mother -- self-esteem, anxiety, and depression were the three things we measured. We measured mother/child relationships, because, again, a major

reason these women are in treatment is because of issues of neglect and abuse of their children.

Moyers: What have you found? How many of them "succeed?"

White: We found significant reductions in substance use; we found dramatic improvements in both self-esteem and in lowering of anxiety and depression scales on women who successfully completed treatment, and we found significant changes in mother/child relationships. We also evaluated it in terms of, Did we have significant reduction in reports of neglect and abusive behavior, and again we got dramatic reductions in both of those categories, so these were two state agencies who looked at that and said, You know, my gosh, this data is so dramatic we can't afford not to continue to put resources into this.

Moyers: Do we know how many people in this country are helped by Alcoholics Anonymous, AA?

White: AA figures, from their own membership surveys, run anywhere from a million to a million and half people in long-term stable recovery in that fellowship.

Moyers: Do you think AA helps people?

White: I don't think there's any question but that AA and a number of other sobriety-based support structures are essential for a large number of people to move into long-term recovery. I say AA and the others for this reason. There are some people who will connect to AA more powerfully than others. The ideas and concepts and rituals within that fellowship which are absolutely transformative for some leave others cold. That doesn't mean those individuals aren't ready for recovery -- some may find alternative sobriety-based support structures that may be every bit as transformative to them. I can give you an example. In some of our outcome studies, when we looked at African-American women in Illinois, in the early weeks and months they were participating in AA and NA and CA. But they were living in a recovery home, so they had a pretty traditional recovery framework. When we came back a year or later, we found significant numbers of those women were using the traditional African-American church as their primary sobriety-based support structure, not the 12-Step fellowships.

Moyers: Someone said to me, if addiction is Rome, there are many roads to Rome and many roads out of Rome. Although the experience is much the same.

White: Absolutely. If you look at the earliest stages of development of addiction problems, they look very, very different. By the time you get to the late stage, it's amazing how similar large numbers of them look, but then we begin to look at people moving out of that and into recovery. The farther you go out, the more roads you discover. We have research on spontaneous remission and maturing out of addiction. I think there's probably a large hidden population of recovered addicts who had significant problems in their relationship with alcohol or other drugs, but moved forward and maintained abstinence without any formal program.

Moyers: But that doesn't happen often enough, does it, that we could take that as policy? There are people who still need treatment.

White: Yes, that's true. The people who mature out may, for example, have less severe problems. They might not be enmeshed in a culture of addiction where all their friends are other users, so they might not need a culture of recovery.

Moyers: What do you conclude from this, what do you say to a family whose son or daughter, husband or wife -- what do you say to a family that's in trouble?

White: Well, clearly, it's not a good idea to tell them to sit back and wait till the person matures out. I think the message still has to

be that this is a disorder with enormous risk, and the risk includes lethality. Large numbers of alcoholics and addicts in this culture die from accidents. Large numbers die from suicides. Significant numbers die from alcohol- and drug-related medical disorders. So I'm going to tend to have the family take an active stance, and at the same time, they also need to know that they cannot change the person if he's not ready.

Moyers: But if we see alcohol and addiction as a disease, can that person take responsibility for his or her own life?

White: It probably depends on what stage of addiction we're talking about. I really believe that there are stages where biology takes over and dominates everything, and if we're asking, Can this person spontaneously, of their own free will, initiate their own recovery?, I think that's probably not possible at such times. And that's important because historically we've always said that nobody can recover unless they get this sort of pure spontaneous desire for long-term sobriety. That's an absolute myth. The vast majority of people that are in long-term recovery got there almost by accident. They stumbled into it and only in retrospect did they reconstruct a story that had a crisis point and motivation that came out of it. They got caught up in recovery in the same way that they got caught up in addiction. In some ways, in spite of themselves. And families and treatment providers can create environments which are most likely to engender that change.

Moyers: What is the impact of addiction on the families as you've seen it?

White: It's dependent on the patterns of addiction. You can have some patterns -- believe it or not, I can have a man sitting in a bed with alcoholic pancreatitis, and I see few problems with his family. The man hasn't missed a day of work in 23 years. However, the dominant pattern that we see in treatment is characterized by a few things which are devastating to families. One is loss of control, and the other one is radical personality change while drinking. A Dr. Jekyll/Mr. Hyde transformation. What this does for families is that it renders family life totally unpredictable. From moment to moment, I don't know if I'm dealing with Dr. Jekyll or Mr. Hyde. In those cases, the addict and alcoholic's role in the family deteriorates so rapidly and so progressively that it restructures all the other roles in the family, and you get all of the traditional problems we have associated with alcoholic families. My favorite metaphor for it is that there's an elephant living in the middle of the living room and no one talks about it until very, very late in the game.

Moyers: What do you say to your own daughter about addiction?

White: I've got a somewhat colorful history, at least on one side of my family, which would suggest a fairly significant risk for addictive disorders, so from the time she's been 9 or 10, I've told her that she needs to be aware of that risk. I tell her that if she has those problems it's got nothing to do with her. It's almost like I'm apologizing ahead of time in terms of any potential genetic responsibility I may have. I don't expect those communications to stop her from having contact with alcohol in this culture, but what I do want to do is have her be an incredibly informed consumer, to make her hypersensitive to the risks. The idea being that if she does develop a problem, it would be difficult for her to maintain denial and minimization.

Moyers: What brought you into this field?

White: I was part of the early community mental health movement, and my niche in that movement was finding a way to organize community alcohol and drug services back in the late 1960s, early 1970s. It really was a reaction to seeing late-stage, highly institutionalized alcoholics in the back wards of state hospitals. I was doing emergency work in jails, and routinely getting called in the aftermath of an alcoholic hanging himself. At that time, hospitals wouldn't take alcoholics with acute medical

trauma, let alone need for detox. Now, paradoxically, 20 years later, those same hospitals have fancy chemical dependency units. They're actively recruiting alcoholics. But the scary thing is it's coming full circle -- in some ways we're swinging back to replicate what I saw early on. We've had an incredible collapse of parts of the treatment system.

Moyers: But the reason for that, as I understand it, is politicians, legislatures, others who say that treatment doesn't work; it has a lousy track record.

White: Yeah, but that is not an accurate assessment of treatment. If you look at the definition of what works, particularly in terms of public institutions, and the issue is, Can we lower the number of hospitalizations of alcoholics through treatment? Can we lower the costs alcoholics cause to society? In terms of all of those social-cost interventions, there are dramatic benefits to a community from treatment, even if people don't even achieve a permanent long-term recovery. The backlash has less to do with the issue of treatment outcome. Most of the time when I hear people say, "Treatment is simply not effective," the people saying that generally have no more data than the people who are standing out there preaching that treatment is effective. They're starting from existential positions of either they're for treatment or they're against it, and everything which comes out of their mouths afterwards justifies wherever they start. However, we are clearly having a backlash against treatment right now, which grew out of abuses in the industry. In the late '80s and early '90s, there was a lot of profiteering. There was a kind of "one model fixes all" idea. And we tried to pound an awful lot of people into one type of treatment which wasn't necessarily appropriate for them. That wasn't particularly successful and may have done some harm. At the same time, I think there's a cultural shift going on right now where we're working to demedicalize the addictions, and recriminalize our approach. It took 40 years of a sustained social movement to get that alcoholic admitted to that hospital bed I was describing, but in a very short period of time we're shutting the doors of those hospitals.

Moyers: What determines now who gets treatment in America?

White: That has changed dramatically in the last five years or so. Through the '80s and early '90s, we had this tremendous explosion in the availability of addiction treatment in the United States. Lots of hospital-based programs, numerous private programs, and fairly well-funded public programs. Between about 1989 and 1992, between 40 and 50% of those private programs closed. Also, in many areas, we had cuts in public funds as well. The main losers here are probably in the middle. We continue to have private treatment programs for the most affluent individuals. The poorest people in this culture can get access to some publicly funded programs. But the middle class in the United States have seen substance-treatment-related benefits erode significantly.

Moyers: What are the barriers to their getting treatment?

White: A decade ago, almost all mainstream insurance companies had a fairly significant substance abuse benefit package. Most people could go, in some cases for multiple episodes, for treatment to the classic 28-day inpatient program. But there were abuses. People were given longer stays than was appropriate, some were repeatedly re-admitted, people whose problems weren't severe enough to warrant inpatient care were hospitalized, often for months. Until somebody ran out of money, and then they were almost abandoned.

Those kind of abuses began to create an incredible backlash within the entire health care system. Suddenly, there were lifetime limits, and then an erosion of inpatient benefits. We began to see aggressive managed care that almost guaranteed that there would be nothing but intensive outpatient programs left, and now we're

even seeing an erosion of coverage for that. Now, in the public sector, managed care is just beginning to swing full force. There are some clients who will do very well in a managed care system. They've got enough stability in their life, family supports, economic stability, etc., that they may do very well in that model, but the women like we've described in Project Safe and other individuals will have great difficulties in those models. In fact, what we're doing is putting them in these very short-term models and then when they fail, we are blaming them for their failure even though we put them in a modality that had almost no reasonable likelihood of success to begin with.

Moyers: That seems almost like a hopeless scenario.

White: It is, and my concern is that as we begin to criminalize this problem, it will only get worse. We may, for example, give this person at the door of the criminal justice system one or two tries at treatment. We give them two very brief little intensive outpatient episodes when they're living in a drug-saturated environment and are coming out of 20 years of addiction. When they relapse, we're then going to say, "OK, you had your chance, now you're going to the penitentiary." What we will have is what we're having now -- penitentiaries absolutely filling up with people on drug-related offenses, busting that system to its breaking point. So recently, we've started coming back with things like the drug court movement, which wants to reinvent the treatment system and reintensify access to care.

Moyers: Talk to me a little bit about harm reduction. One example is needle exchange, which doesn't explicitly seek to stop IV drug use, but tries to reduce the harm caused by dirty needles, like AIDS.

White: The historical controversy around harm-reduction strategies has been the assumption if we provide people needles, or even as a preventionist, if I teach people information about drugs -- like what dose constitutes an overdose -- to lower the likelihood that they will be a casualty of that drug, I am enabling them, encouraging them, actually increasing drug problems in my community. It's the distinction between preventing drug use and preventing drug casualties. Harm reduction is primarily focused at reducing drug casualties. We're going to reduce the number of drug-related deaths; hospital emergency room admissions; HIV- and AIDS-related cases related to substance abuse. I don't think that there's any question that programs like needle exchange have the ability to provide some of that harm reduction outcome. The surprise from my standpoint is that they often have another result. If the person wants to continue to use drugs, as long as they continue to come back and exchange dirty needles for clean needles, it's fine. There's no morality about it. But what we find is that the outreach workers at the needle exchange slowly build a relationship with the addicts. Out of that process, people who previously avoided medical help or treatment began to ask questions about getting into treatment. So harm-reduction strategies can actually help bring people towards abstinence. It's a tremendous, unexpected outcome of some of those strategies. The original assumption that removing the threat of HIV or "enabling" the use of clean needles would reduce the motivation for treatment was wrong.

Moyers: Why do we have such a hard time making up our mind about addiction?

White: If you look at American history, we are eternally ambivalent about these substances. On the one hand, in America we bring a voracious appetite for them. At the same time, the flip side of that is that the efforts to suppress these substances are every bit as intense and animated and aggressive as the search for a good high. So we keep playing out both sides of that almost cyclically for the last couple of hundred years.

Moyers: What is the relationship between science and substance abuse policy?

White: I wish I could tell you that in my reviews of the history of addiction and social policy in America, I've found that science has been the driving force behind that policy, but I can't. Science is more often a self-absorbed bystander than it is a driving force in social policy. We have a long history in this country of state, local, and federal governments generating scientific advisory bodies who then bring the best minds in the country together to ask, "What should we do with this particular aspect of the drug problem?" They then take a year or two or three years and study it meticulously and generate recommendations that are immediately rejected.

Moyers: Because they don't fit the desirable bias?

White: Yes. There's a brief story I can share from the post-repeal area. Ron Roizen's research revealed it. In 1936, the legislature of Virginia decided that, following the repeal of Prohibition, alcohol education needed to be re-evaluated. So they picked two of their leading institutions to study this problem, and they generated a report. Immediately, the draft of this report came under such incredible attack by "dry" forces in the state that the state legislature voted unanimously to have the 1000 copies of this report guarded until such time as they could be burned.

Moyers: What did the report say?

White: It basically described a fairly straightforward objective understanding of what the effects of alcohol in the body were, but given the fact that it didn't immediately come out and demand radical abstinence from all alcohol, it came under very, very bitter attack.

Moyers: It didn't support popular opinion.

White: Right. And we've had others, the marijuana commissions, which tend to support decriminalization, the Ford Foundation report -- we've got a whole host of them. Enormous amount of time and money spent to generate these, and they are completely ignored. On the other hand, we can have a glimpse of a brief scientific report that hardly wouldn't even be called established science. Robert Dupont's early report that methadone programs in Washington, D.C., demonstrated a significant reduction in criminal activity -- that brief preliminary report on a small number of clients drove national social policy. Not because of the science, but because the preliminary conclusion that it drew was very congruent with Nixon's desire to radically reduce urban crime before the 1972 presidential election.

Moyers: So he got behind methadone as alternative.

White: It became the magic bullet. Not as treatment, mind you. It was a way to reduce urban crime in the United States by the quickest means possible.

Moyers: So what can we learn from drug policy history?

White: Drug policy is sort of like a sponge. It absorbs every piece of latent conflict within the culture. And racism plays a very permanent role in most campaigns to criminalize drugs.

Moyers: The fear that blacks will use drugs and alcohol and commit crimes?

White: Well, the campaign to prohibit opium overwhelmingly linked that drug to the Chinese. The movement to increase controls on cocaine was overwhelmingly associated with racist images of blacks. If we move forward, we have the link between heroin and foreign immigrants, particularly in New York City. And at the time we prohibited alcohol -- there's a strong anti-Catholic sentiment tied to it. There's an anti-German feeling tied to the experiences coming out of World War I that's part of the media campaign which led to Prohibition. We have the link between marijuana and Mexican-Americans in the 1930s, which led to the

banning of that drug. If we look at the focused campaigns which result in significant shifts in policy, particularly in terms of criminalization, we see issues of race and social class dominating.

Moyers: If a third of all the white men in Washington, D.C., which would include some members of Congress, were in the criminal justice system because of some drug-related offense instead of it being a third of all young black men, what do you think would be our policy?

White: We have some experience which sheds light on that. We criminalized cocaine and heroin in 1914 through a series of Supreme Court decisions. In 1937, we added marijuana to our list of prohibited drugs. Went into the '50s and dramatically escalated penalties for all those drugs for possession and sale. The men who wrote and passed those laws, in their wildest fantasies, could not have conceived that they would be applied to their own children in the 1960s. As long as it wasn't their family members, they continued to push for harsher and harsher sentences and more enforcement. As soon as we begin to get a large number of middle- and upper-class individuals arrested on drug charges in the 1960s, we know what happened. There was suddenly a movement towards decriminalization. There was a movement towards diversion from prison to alternative sentences. We may be coming back into that kind of cycle right now. Because we're seeing a resurgence of drug use across the board, which will mean that more middle- and upper-class whites will be coming up against these harsh policies.

We're seeing increased use of hallucinogens, LSD, ecstasy. We're seeing increased use of stimulants, but not the cocaine that dominated the '80s, methamphetamine and amphetamine instead. Increased use of solvents. Sedatives are coming back, Rohypnol and other such drugs. All of that is giving a lot of us flashbacks to the 1960s and early '70s. There's also a significant rise in middle-class and affluent heroin use for the first time since the late '60s, early '50s. What that all tells us is that the criminalization which put large numbers of poor African-American men in particular in the criminal justice system since 1980 will now ensnare a significant number of middle-class, affluent, white individuals. I would predict that we will see the same thing. I think the drug court movement will be fueled in non-urban areas by a desire to move middle-class and affluent individuals out of the criminal justice system. Our view of the people who take drugs determines how we will treat them.

Moyers: At the same time, isn't society trying to put some boundaries on substance abuse, trying to say something about its values and about the dangers it senses from uncontrolled transformation of human consciousness with these laws?

White: When we criminalize a drug, probably the real control mechanism there is not the attempt to control supply and punish users and dealers. I think it's a way that the culture can express a value and a judgment. That cultural judgment probably does more to shape whether people use or don't use than the law enforcement does. I think that's a very legitimate function of the law. The difficulty gets to be what happens when we express that judgment, but we have a significant portion of our culture who disagree and breach the law. What they encountered during Prohibition was this sort of difficulty. Are we on the verge here of destroying respect for all law by having certain laws on the books that are blatantly violated by large number of individuals in the culture?

Moyers: Do you think of addiction as a disease?

White: I think there are multiple sub-groups of addicts, and many types of addiction, but yes, there are a number of those subtypes that can accurately be called diseases. I want to lay that out in historical perspective. The very notion of disease starts early. There was Dr. Benjamin Rush in the 1700s, who wrote about the sickness of drunkenness. It

moves into the 1800s, where we get the American Association for the Studying and Cure of Inebriety organized. That organization was founded on the notion that inebriety, which is what they called addiction, was a disease. A whole system of treatment grew up around these notions, but between about 1900 and 1920 it collapses, and we literally lost that whole understanding of addictive disorders as diseases until, following the founding of AA in 1935, we get the rise of the modern alcoholism movement. And there, in the '40s and later, we get a rebirth of the disease concept. They couched the rebirth in scientific language regarding new discoveries about the nature of alcoholism, but the reality was that the science hadn't been completed. The modern alcoholism movement was actually based on a declaration that the alcoholic is indeed sick and is worthy of our help. By the '60s and '70s, when people were surveyed about whether alcoholism is a disease, an overwhelming majority agreed. They weren't talking about science. They were talking about the fact that they believed the alcoholic was sick and that public resources ought to go to support the treatment of that person. But the treatment system born in the 1970s had a pretty narrow idea about what alcoholism was. They saw it as a unitary, progressive disorder which could only be treated in one way. We brought huge numbers of people into treatment that way, and I really want to emphasize that when that model and that language connected with the right people, it was incredibly transforming. The problem was that the science began to catch up with us and began to erode some of the premises of that historical model, so now not only are we experiencing a financial backlash to the treatment system, there's also been an ideological backlash. What we told people was true for all alcoholics simply wasn't, and the science was showing that, as well as people's own experiences. For example, alcohol problems are often not progressive. If anything, they're the opposite. Many people get in trouble with alcohol early, particularly during their late teens and early adulthood, and then mature out of that and never go into the self-accelerating cycle of alcoholism. So the backlash against treatment was not only because of financial abuses, but because providers had defined alcoholism in an overly simplistic manner which didn't fit many of their patients.

That doesn't mean we should throw away the disease concept, just that we may need to refine it. It has done two very important things. The concept itself was probably the most important piece of social engineering in modern history in terms of taking a highly stigmatized disorder and within about two to three decades radically changing how this culture viewed the alcoholic. From that standpoint, the framework of viewing alcoholism as a disease made an enormous contribution by creating an empathetic treatment response. The second thing it has done is to provide a metaphor that alcoholics can use to label what had happened to them and to come to understand it. Whether in fact alcoholism is a disease or not is insignificant compared to the clinical utility of that idea in helping people make sense out of their experiences.

Moyers: It helps them change.

White: Yes. And it's metaphorically true regardless of its scientific status. When we have hundreds of thousands of people standing up saying, I am an alcoholic and I have experienced the disease of alcoholism and now I am in stable long-term active recovery, to the extent that that language helps that process, then it has been a very powerful health-promoting metaphor within our culture.

Moyers: People often change in response to metaphors, and when cultures change their metaphors have to change. So there is an importance to the way we see the world, and the way we see alcoholism.

White: The key part of that is that the metaphors need to fit particular people, because, as you well know, different people use very different kinds of ideas and metaphors in their life to drive change. The

metaphor that is transformative for me could leave you untouched. I could say that the concept of alcoholism as a disease is a way to literally make sense out of 20 years of tragedy in my life, but somebody next to me who shares that same tragedy may stand up and use the metaphor that alcoholism is genocide and use that metaphorical conceptualization to drive radical change in his life as well. Both of us may be abstinent using two radically different ideas.

Moyers: What did you mean when you said in your book, "Follow the money" if you want to understand the problems in regulating alcohol and tobacco?

White: I was trying to convey that there's this struggle within our culture. We have forces that work to inhibit usage of alcohol and other drugs, and we have forces that work to promote those. If you want to understand which side is winning, look at the money. Look at the bottom line. If we compared the advertising budgets of the tobacco industry and the alcohol industry -- just taking two, I'm not even talking about the pharmaceutical industry or any others -- and compared those to what we put in dollars into local primary prevention programs, it might tell us something. If I've got one alcohol brewery which is spending a million dollars a day to promote their product with some of the most sophisticated advertising this century has produced, and I'm given $30,000 for a little prevention program in my community, and we're talking about this is the inhibiting force and this is the promoting force, do we have any guesses of how things may play out? "Follow the money" says that one of the primary strategies of prevention ought to simply be to reduce the promotion forces in the culture. The problem that the government has being the agent for promoting prevention is an enormous conflict of interest. If I tax tobacco and I tax alcohol and generate enormous amounts of money, but, at the same time, my goal is to protect health by dramatically reducing consumption, there's an obvious inherent financial conflict of interest.

Moyers: But how would you go about devising a public health strategy to cut consumption of these drugs?

White: The problem is that it's not just consumption you need to focus on with alcohol, but excessive consumption, because that's where the real profit is. If I can get people to consume more days a week, more beers a week, more beers a day, that means more profits. Of course, those profits don't equate to public health, because as those dosages go up, we get larger ranges of alcohol-related problems. My strategy would be to try to reduce the promoting forces that are pushing people to stretch the boundaries. The primary control mechanism a culture has is rituals to reduce and manage drug consumption. It generates ideas about who can use and when they can use, and where they can use and how much and under what circumstances without being considered deviant. What promoting forces want to do is loosen those controls. And right now, we have incredible promotional forces. We can go in and do all the little prevention programs we want, but in the face of them, those are fairly impotent.

Moyers: So, to reduce alcohol and drug problems, you'd work to increase those cultural controls, those rituals? Right now, the advertising promotes alcohol as a sign of power and success and fellowship, so you'd want to change that?

White: Yes. If we have promotional forces which manipulate images to make these products exceptionally attractive to late adolescents and young adults, we have some major health concerns. The issue is not the presence of those drugs in the culture, but the promotion of those drugs in ways which push excessive use.

Moyers: And that's what we have now.

White: Yes. With crazy contradictions. For almost 25 years, we've had a fairly sustained campaign to stigmatize drunk driving. But at the same time, we provide alcohol at sporting events. The majority of people are

going to get there by driving. We provide, we license the sale of alcohol in filling stations, where you can get cold beer to go in a single container in a bag. Incredible contradictions between, on one hand, what we say is our policy around stigmatizing this, and at the same time we almost ritualize drinking and driving.

Moyers: There are forces in this country who do not want to destigmatize addiction because they think a lot of people don't use because of the stigma.

White: There's probably some truth in that. It's back to that debate over preventing drug use versus preventing drug casualties. If, for example, we begin to move towards decriminalization and even particularly if we went to legalization, imagine turning cocaine over to the advertising sophistication of Anheiser Busch. Obviously the casualty data would just would skyrocket beyond belief.

So if we stigmatize drugs by law, we probably do in some ways contain the number of users. And presumably, if we destigmatize by way of decriminalization, we'll probably have a larger user pool. Some people who wouldn't use the drug illegally, will, if it becomes legal, try that drug. Others would argue that, yes, the user pool will get larger, but the casualty pool would decrease, because the harm related to some of those drugs is not related to their psychopharmacology, it's related to their legal status. An example of that would be heroin. In and of itself, it does not produce HIV and AIDS transmission. HIV transmission comes from the use of shared needles within an illicit drug culture. It's the status of that drug in the culture, not the drug, that makes addiction a primary route of HIV transmission in the United States, because if shooting heroin were legal, no one would need to share needles. So it's the old debate of, Do we shrink the total pool of users or do we try to shrink the casualty population? Our drug policy has been based on the overall assumption that if you shrink the total pool, casualties will go down, but we've had periods where that's not been true. Between 1982 and 1992, by all the surveys, the overall number of illicit drug users in the United States was shrinking, but at the same drug casualties were dramatically escalating. Even though the total number of people using illicit drugs was going down, casualties were going up, because those who were still using were poorer and were using more dangerous drugs, and more dangerous routes of administration, particularly crack cocaine. In 1986, when Project Safe started, there were 297 drug-exposed infants in Illinois. Four years later there were 2,399 drug-exposed infants in my state, almost overwhelmingly related to cocaine use. In four years, even though the total number of users was shrinking, we had this dramatic rise in casualties related to children and families in my state.

Moyers: What does that suggest for drug policy?

White: It means we've got some very, very tough choices ahead of us. I think the trade-off is that, on the one hand, you may want to accept some level of drug casualties. In fact, some people would say we need drug casualties, because drug-related deaths and all those things discourage other people from using. The other side says that we could do some things here by way of harm reduction that as far as we know do not dramatically expand the pool of users. There's fairly good evidence that needle exchanges do not encourage new people to begin using heroin. At the same time, we may be able to dramatically reduce HIV transmission through a needle exchange program. There's going to be a sustained tough debate about, Do we focus our prevention efforts on drug use, or Do we focus those efforts on drug addiction and related problems. A significant area of debate, and enormous controversy surrounding it.

Moyers: Recovering people are largely invisible in our culture. What's the consequence of their invisibility?

White: Let me give you a historical perspective. The alcoholism movement which grew out of the 1940s and generated today's treatment system was powerfully influenced by AA and its traditions of anonymity. That meant that many people believed that standing up publicly and talking about their alcoholism would mean violating the tradition on which their recovery was based. The National Council on Alcoholism started a project called Operation Understanding in the '70s and began not to publicly identify people with AA, but to have large numbers of people from all walks of life publicly declare their prior history of alcoholism and the fact that they had recovered. We see large numbers of drug casualties. Every day we're assaulted by some new baseball player going into treatment for the fifth time, but we don't see visibly as a culture the power of long-term recovery and the stability that it can have. What they did in the 1970s, early 1980s, was to generate some of that kind of movement. Since then my sense is that that kind of visibility has really deteriorated, and we really are back to seeing the worst conceivable images. The current image of treatment is of a ballplayer who just got out for the seventh time and has tested positive again for cocaine.

Moyers: Or a rock singer who dies of an overdose.

White: Yes, so we're seeing casualties, but we don't have the counterpart to that of people who are visibly standing up proclaiming their long-term recovery. I think these things always do tend to go in cycles, so my guess is within the next decade I think we will see the rebirth of a new recovery movement. An advocacy movement to reaffirm this notion that recovery really is possible for a large number of people. And which can hopefully help us tackle some of the difficult choices we need to make in our drug policy.



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. (2000). The history of recovered people as wounded healers: I. From native America to the rise of the modern alcoholism movement. Alcoholism Treatment Quarterly, 18(1), 1-23. Posted at **www.williamwhitepapers.com**

THE HISTORY OF RECOVERED PEOPLE AS WOUNDED HEALERS: I. From Native America to the Rise of the Modern Alcoholism Movement

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

This is the first of a two -part article that outlines the history of men and women who, having recovered from addiction to alcohol and/or other drugs, went on to devote their lives to helping others similarly afflicted. This paper will describe the roles recovered people played in: 1) late 18th and early 19th century Native American cultural revitalization movements; 2) the 19th century temperance movement; 3) 19th century inebriate homes, inebriate asylums and addiction cure institutes; 4) the urban mission movement; 5) the Emmanuel Movement; 6) early alcoholism-focused hospital units, farms and retreats; 7) the Minnesota Model of chemical dependency; and in 8) the birth of industrial alcoholism and halfway house programs.

Introduction

I must combat King alcohol, or else I may yet die a drunkard. George Dutcher, 19th Century Temperance Lecturer (Dutcher, 1872)

I can sympathize with and appreciate the condition of the poor inebriate. Have I not been one of their number? I now have an object in lifeBto reform men. Thomas Doutney, 19th Century Temperance Lecturer (Doutney, 1903)

The concept of the "wounded healer"—the notion that people who have faced and overcome adversity might have special sensitivities and skills in helping others

experiencing the same adversity—has deep historical roots in religious and moral reformation movements and is the foundation of modern mutual aid movements (Nouwen, 1972). This article traces the American origins of a special type of wounded healer: men and women who, having transcended their own addiction to alcohol and/or other drugs, went on to devote their lives to helping the still suffering addict.

The Question of Language

We must begin this exploration with a brief discussion of the rhetoric that has been used to designate those who once had, but no longer have, alcohol- and other drug-related problems. Such terms include: *reclaimed, redeemed*, *reformed*, *reforming*, *arrested*, *dry* (drunkard), *cured*, *sobriate* (a sober inebriate), *recovered*, *recovering*, *ex-* (sot, drinker, drunkard, alcoholic, alcoholist, addict), and *former* or *post* (drinker, alcoholic, addict) (White, 1997). The debate over the most appropriate of such terms dates at least to Harrison's 1860 treatise on the Boston Washingtonian Home in which he makes a special point to refer to men in the Home as *reforming* rather than *reformed* (Harrison, 1860).

Most of the debate over these terms hinges on whether recovery is seen as an enduring process (the "*ing"* suffix) or a life event that can be mastered (the "*ex"* prefix and "*ed"* suffix). The former may have utility to the individual as a reminder that addiction recovery is a dynamic process that requires continued activity and vigilance, while the latter may be helpful in conveying to active alcoholics, their family members, and the public the very real potential for permanent recovery from addiction (Bissell, 1982; McInerny, 1973). The terms "recovering" and "recovered" may also be used to distinguish between those in early stages of recovery from addiction and those who have achieved stable recovery (Blume, 1977).

Both terms will be used in this study: *recovering* to indicate those in early periods of sobriety and *recovered* to indicate those who have achieved a measure of stable sobriety. This distinction is important in light of a history in which individuals with only a fragile hold on their own sobriety have been recruited to work as professional helpers (McGovern, 1992).

Historical Roots: Wounded Healers as Temperance Reformers

The advent of recovering and recovered alcoholics in America devoting themselves to carrying a message of "experience, strength, and hope" to those still addicted to alcohol can be traced to the late 18th and early 19th centuries. This practice was born within two separate cultural contexts: 1) the rise of alcohol-related problems among Native American tribes, and 2) the rise in alcohol-related problems in post-Revolutionary War America. Within both contexts, there emerged a conscious process of addiction recovery and efforts by those in recovery to spread the hope for recovery to others still afflicted.

Native American Temperance Reformers

> *As long as I live, as long as the number of my days is, I will never use it* (alcohol) *again. I now stop*. Handsome Lake, 1800

The use of alcohol as a tool of economic, political and sexual exploitation of Native Peoples has been well-documented (Mancall, 1995; Unrau, 1996). Native American responses to increased alcohol-related problems included using Native healing practices to treat alcoholism, lobbying for a ban on the sale of alcohol, and organizing Native American Temperance societies. Tribal leaders, such as the Delaware Prophet and the Miami Chief Michikinikwa (Little Turtle), waged sustained campaigns against alcohol during the closing decades of the 18th century. It was within this broader pattern of resistance to growing alcohol problems that Native Americans who had themselves experienced such problems launched abstinence-based cultural revitalization movements.

A number of recovered Native American leaders played prominent roles in helping stem alcohol-related problems within their tribes, and many went on to have significant intertribal influence on drinking problems. Samsom Occom, a Mohegan, wrote a widely distributed anti-alcohol pamphlet in 1772 entitled, "Mr. Occom's Address to His Indian Brethren," in which he graphically depicted the role alcohol was playing in the destruction of Native Peoples (Mancall, 1995). In 1800, a Seneca named Handsome Lake had a powerful vision experience that sparked his own recovery from alcoholism and his creation of a new nativist religion based on the practice of total abstinence. He spread his religion by establishing "circles" led by a "holder" who was responsible for teaching what came to be known as the "Code of Handsome Lake." These circles, which evolved into the Six Nations Temperance League, constitute one of the earliest geographically dispersed mutual support structures for alcoholism recovery in America (Cherrington, 1926).

Between 1805 and 1811, a Shawnee Indian named Tenskwatawa (originally Lalawethika, and widely known as "The Prophet") launched a highly effective spiritual revitalization movement. The Prophet assumed this role following a sustained death-like trance from which he awoke and told of his own death, resurrection and deliverance to carry a new religion to his people. Having been known as a notorious drunkard, he established complete rejection of the "White man's poison" and rejection of other trappings of European culture as a cardinal principle of his new religion. He preached that unrepentant drunkards would be forced in the hereafter to drink molten lead until fire poured from their mouths and nostrils. The Prophet's teachings were spread by the Indian political leader, Tecumseh, his brother, who had also been addicted to drink (Edmunds, 1983, 1984); Howard, 1981; Cherrington, 1926).

Another Native American messianic leader was the Kickapoo Prophet, Kenekuk, who in a drunken rage had killed his own uncle. Kenekuk, whose father had also suffered from alcoholism, launched an abstinence-based religious movement that had great influence between 1819 and 1831. This movement blended traditional Native customs and elements of Christianity and was founded on the belief that the very survival of Native Peoples was contingent upon their rejection of alcohol (Herring, 1998; Schultz, 1980).

William Apess was an Ojibway temperance reformer who regularly attacked alcohol in his writings and speeches. His 1829 book, *A Son of the Forest,* constitutes one of the first autobiographical accounts of alcoholism recovery in American literature. The 1847 autobiography of Kah-ge-ga-gah-bowh (George Copway), another Ojibway temperance reformer, detailed his own, and his father's, addiction to "the Devil's spittle" (alcohol) (Mancall, 1995; Cherrington, 1926).

These stories reflect a historically hidden picture of Native Americans recovering from alcoholism, and then using that recovery as a springboard to help other Native Peoples. Samsom Occom, Handsome Lake, Tenskwatawa, Kenekuk, William Apess, and Kah-ge-ga-gah-bowh all found a way to transcend their addiction to alcohol and turn their individual rebirth into broader movements of personal and cultural regeneration. Their individual stories share many common elements: debauchery, a spiritual crisis, vision experiences, a commitment to radical abstinence, a messianic desire to carry a message of hope to others, and the linkage of radical abstinence to a broader process of spiritual and cultural revitalization. The story of the first recovered alcoholics in America who sought to multiply their own recovery through the lives of others begins with these Native American figures. These traditions persist in the continuing history of addiction recovery within and across Native American tribes, from the Peyote Way through today's culturally-nuanced approaches to addiction treatment and recovery (Abbott, 1998).

Alcoholics in the American Temperance Movement

> *They* [reformed men] *understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard's heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform..."* from the Mercantile Journal, May 27, 1841 (Hawkins, 1859)

Alcohol-related problems in America grew between 1790 and 1830 in tandem with rapidly rising alcohol consumption. An awakening cultural consciousness of those problems triggered what Harry Levine has christened the "discovery of addition" and a century of first temperance and then prohibition movements (Levine, 1978).

There were two branches of thought within the 19th century temperance movement. The first branch, gospel temperance, contended that alcoholics were not redeemable and that the best strategy for addressing America's alcohol problems was to let the existing drunkards die off while preventing new drunkards from being formed. Methods to achieve the latter included temperance education, promotion of the temperance pledge, and the legal prohibition of the sale of alcohol. The second branch, therapeutic temperance, sought to rescue the drunkard and to use his experience as a powerful tool to reach still larger numbers of those in need of reformation. The vacillating opinions and blurred lines between these two branches led to large numbers of alcoholics in various stages of recovery working as temperance missionaries and lecturers during the 19th century.

Recovering and recovered alcoholics worked as solo reformers carrying their message of hope through their writings and public speeches, or they worked within

organized temperance and mutual aid movements. As early as the 1830s, men like J.P. Coffin found sobriety within newly created temperance groups and then used the sharing of their own experiences from the lectern as a way to reach others in need of recovery (Steinsapir, 1983).

The Washingtonian Awakening of the early 1840s was the first time that larger numbers of working class alcoholics were drawn into leadership positions within a temperance organization. What these recovering men achieved was to shift the temperance format from one of debate, lectures and speeches to one of "experience sharing." They also recast the drunkard—historically an object of contempt and condemnation—as a person worthy of sympathy and support. The Washingtonian motto, "Let every man be present, and every man bring a man," embedded an evangelical service ethic within this new recovery movement. The Washingtonian Movement was based on premise that no previous temperance effort had gained access to the drunkard's mind and heart and that reformed men could "reach his sympathies, and bid him be a man" (A Member, 1842). Documents of the period suggest this new approach met with considerable success. An intoxicated George Haydock, who attended a Washingtonian meeting with the express purpose of making sport of the speakers, described his response to two Washingtonian speakers, J. F. Pollard and W.E. Wright:

> *...telling the drunkard that he was indeed a man among men, instead of despising and denouncing him, appeared to me quite a new method of talking and seemed to suit my feelings exactly.* (Haydock, 1846)

The Washingtonian Movement generated specialists whose skills in organization and elocution evolved into professionalized roles. Men like John Hawkins and John Gough got sober in the Washingtonian movement and then spent the rest of their lives (1840-1858 and 1842-1886, respectively) working full time in the temperance cause. Hawkins, Gough and many less well-known recovered alcoholics organized local mutual aid societies, carried a message of unrelenting hope through their powerful speeches, maintained prolific correspondence with alcoholics and their families, and provided personal consultations—listening, encouraging, story sharing, and advice giving—to alcoholics and their families as they traveled around the country. Most temperance lecturers supported themselves on meager admission fees or collection plates. Others were provided set fees for their work—fees that while modest for most, eventually made men like Gough quite wealthy (Hawkins, 1859; Gough, 1870).

With the Washingtonian demise in the mid-1840s, many recovered alcoholics were drawn into newly forming fraternal temperance societies, some of which were organized exclusively for recovered alcoholics. Recovered alcoholics continued to reach out to the still-drinking alcoholic through service work within groups like the Sons of Temperance, the Independent Order of Good Templars, the Order of the Good Samaritans, and the Independent Order of Rechabites. The heyday of such groups spanned the years 1842-1880.

During the mid-19th century, we also see the first sustained effort to carry a temperance message to Americans of African descent. The problem of drunkenness among Blacks, which had not been a significant problem during slavery, did increase as first free Blacks and then former slaves (during Reconstruction) gained heightened

access to alcohol (Franklin,1974). Black temperance groups underwent considerable growth after 1830. Some members of groups like the Colored American Temperance Society and the African Temperance Society used these groups for personal recovery or as a means to prevent the risk of addiction to alcohol (James and Johnson, 1996). There are reports as early as 1833 of Blacks addicted to alcohol achieving permanent sobriety within local temperance organizations (Sigorny & Smith, 1833).

Many of the famed Black abolitionists were also involved in the temperance cause. Whether Frederick Douglass should be included among the recovered individuals discussed in this article is open to historical debate. We do know that Douglass bitterly condemned the way in which slave masters used alcohol as a ritualized tool of degradation during slave holidays. We know that he disclosed a period of intemperance in his own life, and that he referred to himself as an "old soker." We know he took the pledge of abstinence in 1845. And we know that he was quite militant in his subsequent personal abstinence and his early support of the temperance cause (Douglass, 1855; Crowley, 1997). Douglass, like the Native American messianic leaders discussed earlier, placed alcohol abstinence within a framework of personal and cultural survival. By advocating abstinence within the historical framework of the drive to abolish slavery and the need to prepare Black people for full citizenship, he presaged modern Afrocentric models of addiction recovery (Williams, 1992).

A new sobriety-based support structure, the reform club, rose in the Northeast in the 1870s and then spread West and South across the United States. The first of such clubs was organized by J.K. Osgood in Gardiner, Maine in 1871 and was followed by Dr. Henry Reynolds' Red Ribbon Reform Clubs, and Francis Murphy's Blue Ribbon Reform Clubs. The reform clubs were mutual aid societies organized by and for alcoholics who met weekly to share experiences and support their mutual recovery.

Reynolds and Murphy went on to full time roles organizing reform clubs and served as mentors to such famed reform club organizers as Lafayette Hughes, Milo Ward, Ed Shiel, Jack Warburton, and Mason Long. Some, like Hughes and Ward, traveled as teams speaking, teaching the ribbon songs, organizing clubs, opening temperance coffee houses, procuring local clubhouses, organizing local ribbon newspapers, and scouring the streets of each new city for drunkards whom-they would feed, cloth, challenge, and encourage. Many a sober, ribbon-adorned drunkard owed their reclamation to such men and the reform clubs they left behind them. The reform clubs embraced the drunkard within an uplifting recovering community whose total efforts were aimed at helping its members achieve an uncompromising goal: *To live and die sober* (Ferris, 1878; Vandersloot, 1878; Hiatt, 1878). Also interesting in light of their modern counterparts were a small number of "moderation societies" founded in the 1870s. These societies brought problem drinkers together for mutual support in their efforts to maintain mutually agreed upon limits as a control on their drinking (Cherrington, 1926).

Involvement in temperance work was not always an assurance of sobriety. The relapse of those with minimal sobriety was not unusual. Even some of the most famous reformed men in the temperance movement, such as Gough, experienced relapse during their careers. Recovering alcoholics who used the temperance lectern as a medium of self-cure often relapsed due to over-exertion and exhaustion. Edward Uniac ignored his friends pleas that he take a rest on the grounds that, "I feel safer from my old enemy when I am fighting in the field of active work." Plagued with continuing relapses, Uniac died in

1869 of an overdose of opium, bromides and whiskey while on a temperance lecture tour in Massachusetts (Berry, 1871, p. 137, 181). His was not an isolated case.

Thomas Doutney tried to engineer his own recovery in 1873 by taking to the temperance lecture circuit. He relapsed the day following his first speech, but then went on to a successful career within the temperance movement (Doutney, 1903). Claude Gunder and Luther Benson each shared their remarkable stories in autobiographies respectively entitled, *Saved by the Blood from a Drunkard's Hell* and *Fifteen Years in Hell*. Gunder's tale of his unrelenting and mostly unsuccessful efforts to get sober ends with his enrollment in a university to prepare himself for work as a temperance lecturer (Gunder, 1908). Benson's story of his drinking before, during, and after giving temperance lectures ends with a suicide attempt and his sequestration in a locked ward of the Indiana Asylum for the Insane (Benson, 1896).

Recovering and Recovered Alcoholics Employed by 19th Century Addiction Treatment Institutions

> *They* [drunkards] *fully understand each other's language, thoughts, feelings, sorrows, signs, grips, and passwords, therefore yield to the influence of their reformed brethren much sooner than to the theorists who speak in order that they may receive applause*. B D. Banks McKenzie, Founder of the Appleton Temporary Home (McKenzie, 1875)

The therapeutic temperance movement birthed America's first addiction treatment institutions as well as her first alcoholic mutual aid societies. This new multi-branched field of addiction treatment included medically-oriented inebriate asylums such as the New York State Inebriate Asylum, religiously oriented inebriate homes such as the Washingtonian Homes in Boston and Chicago, nationally franchised private addiction cure institutes such as the Keeley, Gatlin, and Neal Institutes, and proprietary home cures such as Opacura, Antidote, and the White Star Secret Liquor Cure. Efforts by the inebriate asylums and inebriate homes to professionalize this newly emerging field culminated in the founding of the American Association for the Cure of Inebriety in 1870 and the publication of the first issue of *The Journal of Inebriety* in December, 1876 (White, 1998).

It was perhaps inevitable that recovering and recovered alcoholics would move from their roles in the wider temperance movement to seek employment within these new addiction treatment institutions as physicians, managers and attendants. Physicians in addiction recovery were hired to work in some of these new treatment institutions, particularly within the private addiction cure institutes. By 1900, more than 100 recovering physicians had been hired by The Keeley Institutes (White, 1998). Recovering inebriates also held positions as the managers of some inebriate homes. Most notable in this category was the work of D. Banks McKenzie who in 1872 founded the Appleton Temporary Home in Boston (McKenzie, 1875). Recovering inebriates worked as personal attendants to patients and in non-service roles ranging from accounting to facility and grounds maintenance. The branch of the field that offered proprietary home cures for sale through the mail also included those who claimed they had been cured by a particular remedy and were now offering it to the public (White, 1998).

The use of "reformed men" as managers, physicians and attendants was not without its controversies. The debate over this issue in the closing decades of the 19th century was one of

the most contentious debates within the field. Few were more vociferous on this issue than Dr. T.D. Crothers, Editor, *Journal of Inebriety.* Crothers charged that personal experience of inebriety was not a credential for understanding inebriety and, in fact, precluded such understanding. Crothers claimed that physicians and others who entered into the direct care of inebriates following their own cure were "incompetent by reason of organic defects of the higher mentality" and that the direct care of inebriates rendered the recovering person vulnerable for relapse (Crothers, 1897, 1898, 1902).

Recent research on recovering physicians working in addiction medicine during the late 19th and early 20th centuries does confirm isolated problems of relapse among these physicians (Warsh, 1988; White, 1998). The practice of hiring recovering physicians and managers declined in the late 19th century as the addiction treatment field itself fell into a period of professional and public criticism and decline became the butt of considerable criticism. But the practice of encouraging some of the more stable patients to stay on at a modest salary to serve as cooks, accountants, electricians, carpenters, and grounds keepers within inebriate institutions continued well into the 20th century (Tracy, 1992).

"Reformed" People in the Urban Mission Movement

Religion has long been a framework for personal recovery from addiction in America. There were strong religious underpinnings to the temperance movement, and the scene of alcoholics testifying at 19th century religious revivals that God had taken away their appetite for alcohol was not uncommon. But something special within this history unfolded in 1872 when two recovered alcoholics, Jerry and Marie McAuley, opened the doors of the Water Street Mission in New York City. Jerry and Marie were not likely candidates to lead a religious movement. Both had suffered from alcoholism, Marie had worked as a prostitute, and Jerry had been in prison for highway robbery. The mission was the product of a vision that Jerry McAuley experienced shortly after his religious conversion.

> *One Day I had a sort of trance or vision. I was singing at my work, and my mind became absorbed, and it seemed as if I was working for the Lord down in the Fourth Ward. I had a house, and people were coming in. There was a bath, and as they came in I washed and cleansed them outside, and the Lord cleansed them inside. They came at first by small numbers, then by hundreds, and afterwards by thousands.* (Offord, 1885, p. 37)

The Water Street Mission founded by Jerry and Marie McAuley was the first of America's urban rescue missions that catered their services specifically to alcoholics. Many would follow, and the Salvation Army would, beginning in 1880, make special contributions within this new field of religious rescue work. The urban missions offered the alcoholic food, clothing, shelter, and an opportunity for religious conversion. In their view, recovery from alcoholism was not the primary goal but a secondary consequence of the process of religious rebirth. That message of hope was delivered within the missions by men like McAuley and Samuel Hadley who had themselves recovered from alcoholism through religious experience.

The Water Street Mission sparked the growth of religiously oriented institutions that truly welcomed alcoholics. The urban missions were organized by charismatic figures who, following their own rebirth, experienced a vision of carrying a message of deliverance to other alcoholics. This reformation of self then turned to the reformation of others created an unending chain of service workers in this new American institution. As people got sober within the mission, they were recruited into evangelical roles within expanding mission programs. Many of the later religiously-based alcoholic mutual aid societies, from the United Order of Ex-Boozers (1914) to Alcoholics Victorious (1948), were birthed within the urban rescue mission (Bonner, 1967).

The Rescue Mission is the precursor to modern religiously-based treatment programs that continue to utilize a staff made up largely of recovered alcoholics and addicts. Pursuing religious service as avocation or vocation after one's own recovery from addiction has deep roots in America and constitutes a separate path from those recovered alcoholics who have carried out such service work within addiction treatment institutions.

The Lay Therapy Movement

> *A little knowledge is not a dangerous thing if it is known to be little*. Dwight Anderson, on the importance of lay therapists knowing their limitations (Anderson, 1944, p. 264).

In 1906, the Emmanuel Church in Boston opened a clinic that for the following 23 years combined medicine, religion and psychology in the treatment of a wide spectrum of disorders. The Clinic developed a specialized treatment for alcoholism that involved medical assessment, psychological counseling, participation in a mutual support group (the Jacoby Club), and involvement in acts of service to other alcoholics. There are many elements within the Clinic's operation that left an enduring legacy on the treatment of alcoholism: the combination of individual therapy and educational classes, the use of mentors ("friendly visitors") that were in recovery from alcoholism, social activities, and social work services. The Clinic's founders viewed recovery from alcoholism as a process involving the alleviation of guilt (confession), the acquisition of religious faith, and the active management of emotions and thought through relaxation, suggestion (hypnosis), prayer, and daily self-talk. Most significant for our current exploration, the bulk of the counseling services provided by this Clinic were delivered by "lay therapists" who were former patients in recovery from alcoholism (McCarthy, 1984).

The story of lay therapy within the Emmanuel Clinic begins in 1911 when Courtenay Baylor sought help from the Clinic for his own problems with alcohol. Two years later, Baylor was hired at the clinic as perhaps America's first paid lay psychotherapist specializing in alcoholism. His understanding of alcoholism and the techniques he developed to treat it were set forth in his 1919 text, *Remaking A Man.* In 1922, Richard Peabody came to the Emmanuel Clinic seeking help for alcoholism and was treated by Baylor. Peabody went on to become a prominent lay therapist and wrote one of the most influential 20th century texts on alcoholism, *The Common Sense of Drinking* (1931). What Peabody provided was a remarkably detailed and prescriptive approach to the process of alcoholism counseling and alcoholism recovery. The techniques used by the lay therapists of the 1930s and 1940s were impressive even by today's standards. Lay therapy in the Peabody tradition included such elements as confirmation of resolution for permanent abstinence, medical detoxification where required, contracting mutual cooperation and mutual confidentiality, therapist self-disclosure, story elicitation, bibliotherapy, teaching interventions, construction of a daily schedule, prescriptions regarding daily habits (eating, sleep, exercise), formal relaxation techniques, hypnosis and suggestion, and programmed self-talk (Peabody, 1931; Anderson, 1944; Bishop 1945).

William Wister, Wilson McKay, Samuel Crocker, James Bellamy, and Francis Chambers all were treated by Peabody and went on to pursue careers as lay therapists (McCarthy, 1984). Most of the lay therapists operated private counseling practices in which clients (in the 1930s and 1940s) paid fees that ranged from $10 to $20 per session. Francis Chambers has a special role within this history in that he was the first lay therapist to work not in private practice but within a hospital-based multidisciplinary team. Chambers' clinical collaboration and written work with the psychiatrist Dr. Edward Strecker added considerably to the reputation of lay therapists in the treatment of alcoholism (Strecker and Chambers, 1938). Chamber's decision to work within a broader multidisciplinary team takes on added significance in light of charges that came

from the psychiatric community that lay therapists were practicing medicine (psychotherapy) without a license.

Some recovered alcoholics practiced lay therapy as a part of their own self-cure. They pursued the work quite aggressively—some seeking out candidates for recovery in local bars—as an avocation, with all gratuities donated to local alcoholism councils (Parkhurst, 1941; Bishop, 1945). The lay therapists of the mid-20th century did not have access to their own sobriety based support structures (most did not affiliate with A.A. when A.A. meetings became available) and, with the exception of Chambers, did not have access to regular clinical supervision. It seems that these men used the work itself as a vehicle for their own continued sobriety. But this method was not always a successful one. Several prominent lay therapists experienced relapses after they had entered the lay therapy field, and some left the field believing that the work was detrimental to their continued sobriety (McCarthy, 1984). But lay therapy remained popular into the 1940s. The biography of William Wister notes that fourteen recovered alcoholics visited him in the summer of 1941 seeking his advice and support for their entry into the field of lay therapy (Bishop, 1945).

The Emmanuel Clinic initiated a lay therapy tradition that exerted a profound influence on the future of alcoholism treatment. While recovering and recovered people had worked earlier within American addiction treatment institutions, they had done so in their roles as physicians, managers or attendants. The Emmanuel Clinic marks the beginning of people in alcoholism recovery who specialized in providing psychotherapy for the treatment of alcoholism. While there are earlier elements of alcoholism counseling, it is in the lay therapists of the Emmanuel Clinic that the multiple functions of alcoholism counseling came together within a clearly defined counseling role. Before Baylor and Peabody, the role of the recovered helper had primarily involved the elements of self-disclosure, story elicitation, encouragement and advice-giving. What Baylor and Peabody provided was a structure and a fully developed body of clinical technique for counseling the alcoholic.

Alcoholics Anonymous, Early A.A.-Treatment Linkages, and the Modern Alcoholism Movement

The founding of Alcoholics Anonymous (A.A.) in 1935 marked a turning point in the history of alcoholism and its treatment in America. A.A. provided a fully developed, geographically dispersed, long-term sobriety-based support structure to sustain the sobriety that could be initiated within the context of professionally-directed alcoholism treatment. To enhance the linkage and transition between primary treatment and A.A., treatment institutions began incorporating A.A. concepts and literature into their treatment protocol and eventually began to hire A.A. members as counselors.

The mutually ambivalent relationship between an evolving A.A. and fledgling alcoholism treatment institutions created a zone of ambiguity in which it was difficult to define and delineate A.A. and alcoholism treatment and the roles of A.A. members and alcoholism counselors. There are three key milestones that shaped the relationship between A.A. and alcoholism treatment institutions and established the structure within which A.A. members worked within alcoholism treatment institutions. The first milestone was Bill Wilson's decision in 1936, under pressure from A.A. members, to decline an offer to work as a lay therapist at the Charles B. Towns Hospital and pull A.A. within the umbrella of the hospital. By rejecting Charles Towns' proposal, A.A. avoided being simultaneously professionalized and commercialized (Alcoholics Anonymous, 1957).

The second milestone was the decision by A.A. not to directly own or manage hospitals, retreats, or farms whose purpose was the treatment of alcoholism. What emerged was a position that prohibited A.A. ownership or affiliation with treatment institutions, while allowing cooperation with such institutions by local A.A. groups or individual A.A. members. This allowed A.A. to

maintain a separate identity from the treatment institution with which it interacted. These positions were worked out through A.A.'s earliest experience with hospitals, private sanitaria, alcoholic "retreats" and "farms", psychiatric hospitals, and prisons. These first two milestones tempered A.A.'s, or more precisely Bill Wilson's, vision of carrying the A.A. program to the far corners of the globe through a network of A.A. missionaries and A.A. hospitals (Alcoholics Anonymous, 1981).

The third milestone was A.A.'s definition of the circumstances within which its members could work in paid roles in alcoholism treatment. This came in response to A.A. member-entrepreneurs founding facilities for the care of alcoholics and from A.A. members being recruited for employment in such facilities. There were many A.A. members who served as volunteers, aides and nurses on newly formed alcoholism units in Akron, Cleveland, New York City, and Philadelphia. Teddy R., a nurse recovering in A.A., describes her motivation for such work.

> *After a month of daily increasing happiness, I was struck with an overwhelming sense of gratitude....I felt I must do something in return. When I learned about the A.A. ward at Knickerbocker [hospital] I knew what that something would have to be....I can't convey how much it means to see the transformation in people....To know that I had some small part in this rebirth is a blessing far beyond what I deserve.* (Anonymous, 1989)

Teddy R. went on to a long career working alongside Dr. William Silkworth treating thousands of alcoholics (White, 1998).

Controversies regarding whether A.A. members could work in paid roles in alcoholism treatment institutions were handled first on a case-by-case basis via consultation with Bill Wilson in New York and later were clarified within the framework of A.A.'s Twelve Traditions and specific guidelines issues by A.A. for members who worked within alcoholism treatment programs. The consultations, Traditions and guidelines focused on separating A.A. and its name from alcoholism treatment enterprises and distinguishing the Twelfth Step work performed as an A.A. member from the care that an A.A. member might provide someone as their nurse, social worker, or counselor. Bill Wilson explained this position in a June 2, 1959 letter to an A.A. member:

> *...Therefore the general principle seems to be this: so long as no general appearance of endorsement or alliance is created, there is no reason why an A.A. service person cannot participate in the general field of alcoholism. In short, I do not think there is any traditional reason why he could not do this. But practically speaking, in some circumstances, this may still be undesirable. If, in practical effect, the dual role does actually produce a lot of hostility and friction, then the usefulness of the individual in both roles is compromised. But these are questions of fact and degree—not of principle. This is a matter for estimate by the individual himself and by the groups that surround him....* (From General Service Office of Alcoholics Anonymous Archives)

What grew out of discussions of the role ambiguity and role conflict that could result from A.A. membership and alcoholism counseling was the need for A.A. members working in the alcoholism field to clearly delineate and articulate to their clients and their professional peers when they were speaking/acting as an A.A. member and when they were speaking/acting in their professional capacity. These guidelines paved the way for large numbers of A.A. members to pursue volunteer and paid roles within a growing network of alcoholism treatment programs (A.A. Guidelines).

While A.A. members began to extend their A.A. service work into the more formalized role of alcoholism counseling, a broader movement was underway that dramatically increased the availability of alcoholism treatment in America. Often referred to collectively as the "Modern Alcoholism Movement," organizations such as the Research Council on Problems of Alcohol (1937), the Yale Center of Alcohol Studies (1943), and the National Committee for Education on Alcoholism (NCEA) (1944), worked in tandem in the 1940s to change America's understanding of alcoholism and its response to the alcoholic. The creation of a national network of alcoholism treatment programs in the 1960s and 1970s marked the culmination of this Movement's enduring efforts.

In keeping with the theme of this paper, it is important to note that recovered alcoholics played crucial roles in this Movement. Dwight Anderson outlined the basic elements of the campaign to destigmatize alcoholism (Anderson, 1942). Marty Manns sustained leadership of NCEA and her relentless travels throughout the United States place her among the most important public health reformers of the 20th century. (After helping create alcoholism treatment centers all over the country, she actually worked as an alcoholism counselor late in her life.) Ray McCarthy helped pioneer the Yale model of outpatient alcoholism clinics, the role of alcoholism counselor, and many counseling techniques used within those clinics. It was within the Yale clinics that staff in recovery from alcoholism were first referred to as "counselors" rather than "lay therapists" (Mann, 1973). And the philanthropy and leadership of R. Brinkley Smithers provided crucial support to this movement in the years preceding significant government support for alcoholism treatment.

An important milestone in the evolution of the modern alcoholism movement was the creation of a replicable model of alcoholism treatment and the creation of a replicable alcoholism counselor role. For that milestone, we must visit the State of Minnesota.

The Recovered Alcoholic within the "Minnesota Model"

A.A. membership grew in Minnesota during the 1940s, as it did in many states. That growth provided a medium for the emergence of a new approach to the treatment of alcoholism that came to be known as the Minnesota Model of Chemical Dependency Treatment. his model was the product of a synergy of innovations within and between three institutions: Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950). What emerged was the treatment of alcoholism as a primary disorder, the integration of A.A. concepts and practices within the treatment milieu, the utilization of a multidisciplinary team, the inclusion of recovered alcoholics as volunteers and full time paid staff within that team. While the Minnesota Model would go on to wide replication throughout the United States and beyond, the Model marked a unique milestone in the history of recovered alcoholics working within treatment settings (Spicer, 1993).

While the names of Dr. Nelson Bradley, Dan Anderson, Jean Rossi, Rev. John Keller, and Rev. Gordon Grimm are justifiably linked to the birth of the Minnesota Model, recovered alcoholics such as Pat C., Lynn C., Otto Z., Lon J., Fred E., Mel B. and numerous others helped define this new model and this new alcoholism counseling specialty that was at its core (Richeson, 1978). In 1954, the State of Minnesota formalized this new role by creating a civil service classification entitled, "Counselor on Alcoholism." What is of note in this 1954 decision was not just the title, but that Minnesota had evolved a model that: 1) set minimal standards for this role (a high school education and two years of sobriety), 2) prepared and credentialed the recovered alcoholic to work in the treatment field, 3) paid this person on par with a starting social worker, 4) placed the recovered alcoholic as a legitimate member of a multidisciplinary team, and 5) clarified the boundaries between the recovered alcoholic's status and responsibilities as an A.A. member and as a paid counselor (White, 1998, p 204). The 1954 action drew laughter

from some, outrage from others, and skepticism from many, but it was the beginning of the modern professionalization of alcoholism counseling.

The Wounded Healer in the Workplace

The 1940s and 1950s saw a surge in the roles recovered alcoholics were filling in a re-emerging alcoholism treatment field. In addition to serving in the previously discussed roles of lay therapist, retreat manager, and the newly christened role of counselor on alcoholism, recovered alcoholics were working in more varied settings and extending the reach of their professional service activities. Recovered alcoholics began working in psychiatric hospitals that had created "patient-counselor" positions through which selected alcoholics could move from the status of patient to staff member on an alcoholism ward. But these experiments paled compared to what was occurring in the workplace.

A.A. members in the workplace began suggesting to their companies that there were ways to effectively intervene with alcohol-impaired employees. These informal helping roles evolved into formal occupational alcoholism programs as recovered alcoholics like David M., Warren T., and Earl S. assumed full time positions in the early 1940s counseling alcoholics at Remington Arms, DuPont, Kaiser Shipyards, and North American Aviation. If there was a single person most responsible for selling occupational alcoholism programs during the 1940s and 1950s, it would undoubtedly be Lefty Henderson. Henderson, working first with NCEA and then with Yale, used his own recovery story and his remarkable communication skills to convince business leaders across the country that the alcoholic employee could be identified, rehabilitated, and restored to full productivity. The model of intervention advocated by Henderson involved the designation of a coordinator, generally a recovered alcoholic already working within the company, to create a company policy on alcoholism, orient supervisors and employees, and link impaired employees to alcoholism treatment and recovery resources (Henderson and Bacon, 1953).

As more alcoholics entered recovery without economic or family support, there emerged a need for a place where such men and women could live in a supportive environment until they could get back on their feet physically, emotionally and financially. This need birthed a new institution, the halfway house, whose managers and staff were overwhelmingly drawn from those in personal recovery from alcoholism (Cahn, 1969; Barrows, 1979). The alcoholism halfway house movement of the 1950s was in many ways a formalization and extension of support that had been provided by A.A.'s co-founders, many A.A. sponsors, and by early A.A. clubhouses.

Preview

In the second half of this article, we will explore the roles recovered alcoholics and ex-addicts played within the rise and evolution of modern addiction treatment institutions. The article will conclude with a discussion of how the roles of recovered people as wounded healers have changed over the past 200 years.

REFERENCES

A Member of the Society. (1842). *The Foundation, Progress and Principles of the Washingtonian Temperance Society of Baltimore, and the Influence it has had on the Temperance Movements in the United States*. Baltimore: John D. Toy.

A.A. Guidelines for A.A. Members Employed in the Alcoholism Field. (ND). New York: General Service Office, Alcoholics Anonymous.

Abott, P. (1998). Traditional and Western Healing Practices for Alcoholism in American Indians and Alaska Natives. *Substance Use & Misuse* 33(13):2605-2646.

Alcoholics Anonymous. (1957). *Alcoholics Anonymous Comes of Age: A Brief History of A.A.* NY: Alcoholics Anonymous World Services, Inc.
Alcoholics Anonymous, 1981) *Twelve Steps and Twelve Traditions.* (1981). NY: Alcoholics Anonymous World Service, Inc.
Anderson, D. (1942). Alcohol and Public Opinion. *Quarterly Journal of Studies on Alcohol*, 3(3):376-392.
Anderson, D. (1944). The Place of the Lay Therapist in the Treatment of Alcoholics. *Quarterly Journal of Studies on Alcohol*, (September), pp. 257-266.
Anderson, D. (1950). *The Other Side of the Bottle*. New York: A. A. Wyn.
Anonymous (1952). I'm a Nurse in an Alcoholic Ward. *Saturday Evening Post*. October 18, pp. 40-41, 111-116.
Baylor, C. (1919). *Remaking a Man.* NY: Moffat, Yard & Company.
Benson, L. (1896). *Fifteen Years in Hell: An Autobiography*. Indianapolis: Douglas & Carlon.
Berry, J. (1871). *UNIAC: His Life, Struggle, and Fall*. Boston, MA: Alfred Mudge & Son.
Bishop, J. (1945). *The Glass Crutch: The Biographical Novel of William Wynne Wister.* NY: Doubleday, Doran & Co., Inc.
Bissell, L. (1982). Recovered Alcoholic Counselors. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism.* New York: Gardner Press, pp. 810-817.
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.* New York: Plenum Press, pp. 545-565.
Bonner, A. (1967). *Jerry McAuley and His Mission.* Neptune, NJ: Loizeaux Brothers.
Chambers, F. (1937). A Psychological Approach in Certain Cases of Alcoholism. *Mental Hygiene,* 21:67.
Chambers, F. (1968). *The Drinker's Addiction: Its Nature and Practical Treatment*. Springfield, IL: Charles C. Thomas.
Cherrington, E. (1925-1930). Ed. *Standard Encyclopedia of the Alcohol Problem.* (Six Volumes). Westerville, Ohio, American Issue Publishing Company.
Crothers, T.D. (1897). Reformed Men as Asylum Managers. *Quarterly Journal of Inebriety* 19:79-81.
Crothers, T.D. (1898). Editorial: Study of Inebriety. *Journal of Inebriety*. 20(1): 111-113.
Crothers, T.D. (1902). *Morphinism and Narcomanias from other Drugs.* Philadelphia: W.B. Saunders & Company.
Crowley, J. (1997). Slaves to the Bottle: Gough's Autobiography and Douglass's Narrative. In: Reynolds, D. and Rosenthal, D. *The Serpent in the Cup: Temperance in American Literature*. Amherst: University of Massachusetts Press.
Douglass, F. (1855). *My Bondage and My Freedom*. NY: Miller, Orton, & Mulligan.
Doutney, T. (1903). *Thomas Doutney: His Life Struggle and Triumph*. Battle Creek, MI: The Gage Printing Company, Limited.
Dutcher, G. (1872). *Disenthralled: A Story of My Life.* Hartford, Connecticut: Columbian Book Company.
Edmunds, D. (1983). *The Shawnee Prophet*. Lincoln: University of Nebraska Press.
Edmunds, D. (1984). *Tecumseh and the Quest for Indian Leadership*. Boston: Little, Brown and Company.
Ferris, G. (1878). *The Life and Work of Francis Murphy and Dr. Henry A. Reynolds.* NY: Henry S. Goodspeed & Company.
Franklin, J. (1974). *From Slavery to Freedom.* NY: Knopf.
Gough, J. (1870). *Autobiography and Personal Recollections of John B. Gough.* Springfield, MA: Bill, Nichols & Company.
Gunder, C. (1907). *Life of Clause A. Gunder; Saved by the Blood from a Drunkard's Hell*. Marion, IN.

Harrison, D. (1860). *A Voice From the Washingtonian Home.* Boston: Redding & Company.
Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.
Haydock, G. (1847). *Incidents in the Life of George Haydock, Ex-Professional Wood-Sawyer*. Hudson: Columbia Washingtonian Print.
Henderson, R. And Bacon, S. (1953). Problem Drinking: The Yale Plan for Business and Industry. *Quarterly Journal of Studies on Alcohol*, 14:247-262.
Herring, J. (1988). *Kenekuk, the Kickapoo Prophet*. Lawrence, KS: University Press of Kansas.
Hiatt, J. (1878) *Save the Boys: The Ribbon Workers*. Hastings, MI: LaFayette Hughes.
Howard, J. (1981). *Shawnee! The Ceremonialism of a Native Indian Tribe and its Cultural Background*. Athens: Ohio University Press.
Humphreys, K., Noke, J., and Moos, R. (1996). Recovering Substance Abuse Staff Members' Beliefs about Addiction. *Journal of Substance Abuse Treatment* 13(1):75-78.
James, W. and Johnson, S. (1996). *Doin' Drugs: Patterns of African American Addiction.* Austin: University of Texas Press.
Leslie E. Keeley Company Physician's Record (1891-1950) Keeley Archives. Illinois State Historical Society, Springfield, IL.
Levine, H. (1978). The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. *Journal of Studies on Alcohol*, 39(2):143-174.
Mancall, P. (1995). *Deadly Medicine: Indians and Alcohol in Early America*. Ithaca, NY: Cornell University Press.
Mann, M. (1973). Attitude: Key to Successful Treatment. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield, IL: Charles C. Thomas Publisher, pp. 3-8.
McCarthy, K. (1984). Early Alcoholism Treatment: The Emmanuel Movement and Richard Peabody. *Journal of Studies on Alcohol*, 45(1):59-74.
McGovern, T. (1992). Alcoholism and Drug Abuse Counseling: A Personal Reflection. *The Counselor*, 10(3):38-46.
McKenzie, D. (1875). *The Appleton Temporary Home: A Record of Work.* Boston: T.R. Marvin & Sons.
McInerney, J. (1973). Alcoholics Anonymous Members as Alcoholism Counselors. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: IL: Charles C. Thomas Publisher, pp. 91-105.
Nouwen, H. (1972). *The Wounded Healer*. New York: Doubleday.
Offord, R. (1885). *Jerry McAuley: An Apostle of the Lost*. Harrisburg, PA: Publication House of the United Evangelical Church.
Parkhurst, G. (1941). Laymen and Alcoholics. *Harper's Magazine,* 1096:422-429.
Peabody, R. (1931). Psychotherapeutic Procedure in the Treatment of Chronic Alcoholism. *Mental Hygiene*, 14:109-128.
Peabody, R. (1930). Psychotherapy for Alcoholics. *New England Journal of Medicine*, 202:1195-1202.
Peabody, R. (1936). *The Common Sense of Drinking*. Boston: Little, Brown, and Company.
Peabody, R. (1936). The Danger Line of Drink. *Scribner's Magazine* (June), pp. 370-372.
Richeson, F. (1978). *Courage to Change.* U.S.A.: M & M Printing.
Royce, J. (1986). Recovered Vs. Recovering: What's the Difference? *The U.S. Journal* March, p.7.
Schulstad, M. (1998). Transcribed Personal Interviews, July 2 and July 17.
Schultz, G. (1980). Kennekuk, the Kickapoo Prophet. *Kansas History* 3(Spring):38-46.
Sigorney, L. and Smith, G. (1833). *The Intemperate and the Reformed*. Boston: Seth Bliss.
Spicer, J. (1993). *The Minnesota Model: The Evolution of the Interdisciplinary Approach to Addiction Recovery.* Center City, MN: Hazelden Educational Materials.

Steinsapir, C. (1983). The Ante-Bellum Temperance Movement at the Local Level: A Case Study of Schenectady. New York: Ph.D. Dissertation, Rutgers University.

Strecker, E. and Chambers, F. (1938). *Alcohol: One Man's Meat.* NY: The MacMillan Company.

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

Unrau, W. (1996). *White Man's Wicked Water: The Alcohol Trade and Prohibition in Indian Country, 1802-1892.* Lawrence, KS: University of Kansas Press.

Vandersloot, Rev. S. (1878). *The True Path; or Gospel Temperance: Being the Life, Work and Speeches of Francis Murphy, Dr. Henry Reynolds, and Their Co-laborers*. New York: Henry S. Godspeed & Co.

Warsh, C. (1988). Adventures in Maritime Quackery: The Leslie E. Keeley Gold Cure Institute of Fredericton, N.B. *Accedences* 17(2):109-130. (Spring).

White, W. (1999). The Lessons of Language: Historical Perspectives on the Rhetoric of Addiction. In: Tracy, S. and Acker, C. Eds. *Historical Perspectives on Alcohol and Drug Use in American Society, 1800-1997.* Amherst: University of Massachusetts Press. (In Press)

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

Williams, C. With Laird, R. (1992). *No Hiding Place: Empowerment and Recovery for Troubled Communities*. NY: Harper San Francisco.



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. (2000). The history of recovered people as wounded healers: II. The era of professionalization and specialization. Alcoholism Treatment Quarterly, 18(2), 1-25. Posted at **www.williamwhitepapers.com**

THE HISTORY OF RECOVERED PEOPLE AS WOUNDED HEALERS: II. The Era of Professionalization and Specialization

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

Part I of this article traced the history of recovered alcoholics as wounded healers from their roles in late 18th century Native American cultural revitalization movements and the American temperance movement through their work as lay therapists and counselors within outpatient counseling clinics, Minnesota Model inpatient programs, industrial alcoholism programs and halfway houses. This article will focus on how the roles of the "paraprofessional" recovered alcoholic and ex-addict evolved into the professionalized role of the modern addiction counselor.

The Ex-Addicts

The history of the wounded healer in the addiction recovery arena was until the mid-twentieth century a story almost exclusively about those recovering from alcoholism. Three events between 1947 and 1965 brought people in recovery from addiction to drugs other than alcohol into paid helping roles within an emerging national network of addiction treatment programs. The first event was the emergence of Narcotics Anonymous (N.A.) between 1947 and 1953. N.A. provided a counterpart to A.A. for those addicted to drugs other than alcohol and created a pool of recovered addicts from which addiction treatment agencies could recruit staff.

The second event was the founding of Synanon by Charles Dederich in 1958. This milestone marked the birth of therapeutic communities (TCs) for the treatment of drug addiction. In its early years, this model was exclusively staffed by "ex-addicts" drawn from the growing pool of rehabilitated clients. The dramatic spread of TCs created a large market for the newly created role of professional ex-addict.

The third milestone was the emergence of methadone detoxification and maintenance in 1964-1965. This new treatment modality also incorporated a large number of ex-addicts to work as counselors. Expanding treatment modalities-organized into ideological camps openly hostile to one another--were eventually integrated into large multi-modality treatment systems. Ex-addict staff, in addition to performing key clinical functions and serving as role models for their clients, provided a cultural bridge between the addicted clients and the professional staff (Senay, 1981; Senay, 1989).

This first generation of professional ex-addicts were strongly linked to the institutions within which they had been treated, but were rarely linked to such long term mutual aid societies such as A.A. or N.A.

Growing Federal Involvement

With replicable alcoholism and other drug addiction treatment modalities available, the challenge was to replicate and refine these programs in communities across the country. Alcoholism programs spread through the support of funds from multiple federal agencies. The Organization for Economic Opportunity (OEO) established alcoholism services within more than 200 local anti-poverty programs. The OEO programs relied almost exclusively on recovered alcoholics to help alcoholics and their families gain access to needed medical and rehabilitation services. The National Institute on Mental Health incorporated alcoholism services within the newly funded comprehensive community mental health centers where recovered alcoholics were hired as counselors to work alongside psychiatrists, psychologists and social workers. The Law Enforcement Assistance Administration funded social setting detoxification and other criminal justice diversion programs. The social setting detox programs became ports of entry for large numbers of recovering people wishing to work in the alcoholism treatment field. Recovered alcoholics such as Congressman C. Elliot Hagan and Matt Rose (at OEO) played important legislative and administrative roles in creating such programs and blessing the incorporation of recovered alcoholics into key staff positions within these new treatment initiatives.

The renewed practice of using recovered alcoholics as professional helpers, as in earlier periods, stirred considerable controversy. The flavor of this controversy was revealed in a 1963 debate between two Michigan psychiatrists, Dr. Henry Krystal and Dr. Robert Moore, over the question of who was qualified to treat the alcoholic. Dr. Krystal opposed the use of recovered alcoholics as treatment specialists on the grounds that they had often not worked through their own emotional problems and that they were not equipped to deal with the clinical complexities that alcoholism presented. Dr. Moore countered that traditional helpers, particularly psychiatrists, had not been particularly effectively in treating alcoholics and that many institutions were successfully incorporating recovered alcoholics into their alcoholism treatment teams (Krystal and Moore, 1963).

One factor that tipped the scales toward the use of recovered alcoholics as counselors was the existence of contemporaneous movements to use trained lay workers in related fields--mental health, child welfare, criminal justice, education and community action (anti-poverty programs) (Grosser, et.al., 1969; Rosenberg, 1982; Reiff & Reissman, 1964; Briggs, 1963). The beginning of what came to be referred to as a “paraprofessional movement” was launched in a 1959 report of the Joint Commission for Mental Health and Illness that called for a broadening of the mental health delivery team to include the use of indigenous community volunteers as paid service providers (Pattison, 1973). The subsequent studies of Carkhuff and his colleagues confirmed that paraprofessionals could be trained to provide effective counseling services related to a wide spectrum of personal problems (Carkhuff and Truax, 1965; Carkhuff, 1969, 1971). This broad paraprofessional movement providing a legitimizing context to the reborn

contention that recovered alcoholics could play valuable service roles in the treatment of alcoholism.

The growing practice of hiring A.A. members to work in various roles in alcoholism treatment programs continued to stir controversies in some local A.A. groups. Re-emphasizing the importance of the separation between A.A. and treatment programs and between Twelfth Step work and alcoholism counseling, the General Service Conference of A.A. went on record as opposing what was becoming the frequent use of the title, “A.A. Counselor,” and rejected use of the term, “two-hatter” for the preferred, “A.A. member employed in the field of alcoholism” (Alcoholics Anonymous, 1970; Alcoholics Anonymous, 1975). The intensity of these debates subsided as clear guidelines emerged within A.A. about how A.A. members could work in the alcoholism field while clearly delineating their paid activities from their A.A. service activities. Independently sponsored national conferences, beginning in 1977, also helped recovered alcoholics and “coalcoholics” explore the problems and opportunities of working in the alcoholism field (The Fifth “Two Hatter”..., 1981).

Growing public concern with youthful polydrug abuse spurred additional federal, state and local funding to new youth-oriented services: street drug testing services, outreach (“streetwork”) programs, emergency services (crisis lines and “acid rescue”), school-based early intervention programs, outpatient drug free counseling centers, and short term residential centers. These new modalities incorporated a growing number of recovering polydrug addicts in staff positions. The recovering polydrug users who filled such roles often existed in limbo within the broader field of addiction treatment and within the broader recovery community. At a professional level, they didn’t identify with those working in alcoholism treatment programs, the TCs or the methadone programs, and, at a personal level, they often felt little identification with A.A. or with N.A. (which at this time was dominated by recovering heroin addicts).

Toward a Treatment System

In the early 1970s, the federal government acted to both expand and organize alcoholism and addiction treatment services. The plan called for a partnership between newly created federal agencies--the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA)--and designated alcoholism and drug abuse treatment authorities within each state and territory. Recovered alcoholics and recovered addicts from across the country played pivotal roles in the drive to create the enabling legislation that supported this new structure to plan, build, staff, operate, and evaluate alcoholism and drug abuse treatment programs in local communities across the country. In the case of the 1970 Comprehensive Alcoholism Prevention and Control Act, a recovered alcoholic (Senator Harold Hughes) introduced the funding Bill. Recovered alcoholics, (from Bill Wilson to noted Actress Mercedes McCambridge to Marty Mann), testified at the hearings regarding the legislation, and politically influential recovered alcoholics (particularly R. Brinkley Smithers) played a critical role in preventing a planned presidential veto of the legislation.

During this same era, two other formal branches of the nation=s treatment system emerged. The growing trend by insurance companies to reimburse treatment for alcoholism led to the rapid growth of hospital-based and private for-profit addiction treatment units. Growing concerns about alcohol and other drug problems in the military also led to an expansion and formalization of treatment services within the U.S. military and within the Veterans Hospitals and local service centers. Paralleling what was occurring in civilian communities, recovered alcoholics played seminal roles in birthing alcoholism intervention and treatment services in the U.S. military.

Looked at as a whole, it appeared that the nation was declaring war on alcohol and other drug problems in the 1970s, but the nation had no troops prepared to wage this war. It was in this vacuum that a "new profession" was born. New agencies and a new profession to treat alcoholics and addicts emerged to fill a void created by the contempt with which alcoholics and addicts were regarded by traditional helping professionals. Recovered people shaped the new role of specialized work with alcoholics and addicts because psychiatrists, psychologists, and social workers had consistently made clear that they did not want such a role (Pattison, 1973).

The Beginnings of a "New Profession"

Between 1965 and 1975, virtually thousands of recovered alcoholics and addicts were enlisted in a wide variety of helping roles within newly emerging alcoholism and drug abuse treatment programs. They were often recruited directly out of treatment or out of local mutual aid societies. They worked as counselors, aides, psychiatric technicians, and house managers. Recovering and recovered people who were physicians, nurses, psychologists and social workers were also drawn to the field at this point.

Mel Schulstad, who played a pioneering role in the professionalization of the alcoholism counselor, describes what it was like for those without degrees in this pre-professionalization stage of the field.

> *We were regarded as something of an oddity. Some of the professionals worried that they were going to have to clean us up and that we might get drunk a week after we were hired. They didn't know what to expect. The only way an alcoholism counselor could get some kind of credibility was to venture up to Rutgers Summer School of Alcohol Studies, go to school for a few weeks, and come home with a piece of paper that you could hang on the wall. Graduate of Rutgers was about the highest qualification you could get. This new profession had no standing whatsoever with the older professions which based their credibility on academics. Their attitude was, "Who the hell are you to tell us anything?" And yet these were the very people who had failed miserably in their efforts to help the alcoholic. Slowly they began to see what we could do and even began to approach us to help members of their own families who were struggling with alcoholism*. (Schulstad, 1998)

Some new members of this field entered recovery through the auspices of addiction training, perhaps drawn to the field like many before them in hopes of working out their own problematic relationship with alcohol or other drugs. For example, of the 475 physicians who participated in addiction training at the Long Beach Naval Regional Center between 1974 and 1978, 44 signed themselves into treatment before pursuing continued work in addiction medicine as recovering physicians. By 1982, more than 200 recovered physicians had entered the reemerging field of addiction medicine (Of the 475..., 1978; Bissell, 1982).

As a whole, the roles of those recovered people working in alcoholism and drug abuse counseling were ill-defined. They carried individual caseloads as high as 50 clients (Senay, 1989). They worked an unconscionable number of hours per week at rates of pay that would be incomprehensible by today's standards. But they laid the foundation of a new field with their passion, their commitment, and their instincts about what was needed to incite the process of addiction recovery.

A rarely told story of this period was the casualties that were part of the process of building this foundation, and many of those casualties involved episodes of relapse by those working in helping roles in the earliest days of many modern treatment programs. While such relapses were nearly always attributed to factors within the individual, recovering people working within

addiction treatment settings in the early to mid-1970s often did so under conditions that inadvertently undermined their continued recovery (White, 1979). Dr. John Norris, the Nonalcoholic Chairmen of A.A.'s General Service Board, noted during this period that many A.A. groups were making significant contributions to the alcoholism field. But he went on to warn that A.A. members invited to work as alcoholism counselors with no qualifications for counseling other than their A.A. membership often discovered that they were unable to cope with the demands and stresses of a job for which they were ill-prepared (Norris, 1970).

What is perhaps surprising in retrospect, is not that there were relapses, but that there were so few relapses in the days before all of the modern supports of preparation, screening, orientation, supervision, and dual relationship discussions were in place.

"Combined Treatment" and the Recovered Counselor

The recovered alcoholics working in alcoholism programs and the ex-addicts working in drug treatment programs operated in separate worlds through much of the 1960s and 1970s. Recovering alcoholics were known to dabble with prescription (and sometimes illicit) drugs, all the while proclaiming their continued sobriety. Many ex-addicts, some treated in programs where they had earned the right to drink as a privilege, went on to develop serious problems in their relationship with alcohol. And both groups were notorious chain-smokers. It was only a matter of time before the contradictions created by such categorical thinking came to a head.

The call to integrate alcoholism and drug abuse treatment within a single conceptual umbrella emerged as the most wrenching professional issue within the alcoholism and drug abuse fields from the early 1970s to the early 1980s. The person most responsible for clinically bridging the chasm separating these two fields was Dr. Donald Ottenberg of Eagleville Hospital and Rehabilitation Center in Pennsylvania. While proposals to integrate local and state treatment agencies, professional associations, and counselor credentialing bodies stirred debates of unprecedented intensity, nearly all of these debates eventually gave way to the forces of integration.

The movement to integrate the alcoholism and drug abuse treatment fields exerted a profound influence on the role of recovered people working in these two fields. For years the recovered alcoholic's most essential qualification had been defined as his or her capacity for alcoholic-to-alcoholic identification. When suddenly those addicted to drugs other than alcohol were assigned to this recovered alcoholic counselor, the source of that identification--the essence of his or her perceived credibility--was compromised. This process forced many recovered alcoholics and ex-addicts to redefine the assets they brought to the helping process. It also spurred the need for new knowledge and skill development for counselors who quickly realized that they needed much more than their personal story of recovery to operate effectively as an addictions counselor.

Professionalization, Privatization, and Specialization

The 1970s and 1980s witnessed three trends that exerted a profound influence on recovered people working in addiction treatment settings. The first of these trends—professionalization--was marked by two major milestones. The first milestone was the establishment of training programs for those working in alcoholism and drug abuse treatment programs. Early (1966-1972), training initiatives were developed by the Office of Economic Opportunity, the Department of Labor, and the National Institute on Mental Health. These were then followed by NIAAA and NIDA's development of formal addiction counselor training systems between 1973 and 1979. NIAAA and NIDA created national, regional and state training programs that conducted training needs assessments, created training curricula, trained trainers, and delivered and evaluated training. They also encouraged the development of external degree

programs and graduate programs to enhance the credibility of a large portion of the treatment workforce that lacked academic credentials. The focus of these initiatives was to turn a large (some 45,000 workers) and largely untrained "paraprofessional" workforce that lacked credibility into a professional workforce that could take its place alongside more traditional helping disciplines (Over 200..., 1972; Davis and Ford, 1980). There was a debate during this period regarding whether alcoholism and drug abuse counselors should become a "new profession" or whether they should be trained as specialists within such existing professional disciplines as psychology, social work, and counseling. Strong advocacy for the former eventually tipped the scales toward creating a new professional specialty of addiction counseling. Implicit within this transition was the decision that addiction counselors would no longer remain "paraprofessionals" working under the supervision of "professionals" but would instead seek to emerge as professionals in their own right (Valle, 1979).

The second milestone of professionalization involved the development of professional associations and credentialing processes for addiction counselors. These activities occurred at both state and national levels. National addiction counselor associations can be traced to the founding of the National Association of Alcoholism Counselors and Trainers (1972) which evolved into the National Association of Alcoholism Counselors (1972) and, subsequently (1982), became today's National Association of Alcoholism and Drug Abuse Counselors (NAADAC). State credentialing and certification systems for alcoholism and drug abuse counselors spread in the 1970s, with addiction counselor credentialing mechanisms in place in 23 states by 1979 (Camp and Kurtz, 1982). Competing national addiction counseling credentials were offered by the American Academy of Health Care Providers in Addictive Disorders, the National Certification Reciprocity Consortium, and NAADAC. The foundation of these credentialing efforts was laid by a series of technical reports--the Roy Littlejohn Report (1974), the University Research Corporation and the Medical College of Pennsylvania's reports on drug abuse counselor functions (1975-1977), the Finger Panel Report (1977), and the Birch and Davis Report (1983)--that collectively tried to move addiction counseling from a folk art to a professional discipline by defining the knowledge and skill components of addiction counseling and recommending approaches to the training and credentialing of addiction counselors. What emerged was a patchwork system of competing national and state certification bodies, registries, civil service classifications, and licensure movements (Mitchell, 1981). Debate continues on relative value of these various approaches to credentialing and whether such systems have improved the quality of treatment and effectively protected the public from harm by incompetent practitioners.

The advent of addiction counselor training programs and the advent of counselor certification and licensure created a situation where recovered staff without degrees either obtained degrees or alternative credentials (certification) or drifted out of the field. This trend toward professionalization was particularly difficult for those who lacked a high school education, lacked full literacy, lacked prior experience with job interviewing and testing and, not uncommonly, had prior criminal records. Many such workers were filtered out of the system during this move toward professionalization.

The major transition in this period was from a situation where recovered people began working as counselors and then obtained training, to a situation where people obtained training *before* they begin working in the field. There were also growing numbers of other professionals entering the addictions field who did not bring backgrounds of personal recovery.

A second trend, the privatization of addiction treatment, was influenced by the development in the early 1970s of accreditation standards for alcoholism treatment programs and a shift by the insurance industry to reimburse costs for alcoholism treatment. These changes spawned a rapid proliferation of hospital-based and private, freestanding alcoholism treatment programs that catered to a more affluent class of clients. This trend further exerted pressure to elevate the knowledge, skills, appearance and interpersonal skills of those working as addiction

counselors. One dimension of the trend toward privatization was the opening of a market for private addiction counseling. With the availability of third party reimbursement for such services, credentialed people in recovery worked within solo or group private counseling practices for the first time since the early 20th century lay therapists (Schmidt, 1993).

As the field became professionalized and more privatized, a third trend— specialization--emerged. Recovered people could not only acquire professional credentials, they could also specialize in work in particular settings (hospitals, schools, military, workplace, criminal justice system, or child welfare system). They could specialize in working with clients with particular drug choices. And they could specialize in work with particular types of clients (women, adolescents, the elderly, clients of color, gays and lesbians, the deaf, the dually diagnosed, or other special needs groups). Recovering people pushed treatment institutions and mutual aid societies toward greater responsiveness to the needs of special groups and created new intervention choices. Two examples are particularly noteworthy. Dr. Vernon Johnson used his own recovery experience and his frustration with the traditional position that alcoholics couldn't be helped until they had hit bottom to pioneer new techniques of family intervention that brought thousands of alcoholics into treatment. Dr. Jean Kirkpatrick, reacting to her own struggles getting sober within A.A., formulated a sobriety-based support group based exclusively on the experiences and needs of addicted women. The resulting group--Women for Sobriety--provided an alternative or adjunct to A.A. for many recovering women.

The rise of groups like Women for Sobriety (1975), Secular Organization for Sobriety (1985), and Rational Recovery (1986) brought recovered people into professional helping roles in addiction treatment who did not come from a traditional Twelve Step recovery background. There were also a growing number of recovered people carrying a message of hope to addicts through cultural and religious frameworks of recovery. Recovered people working in the field of addiction treatment moved from a homogenous group to one that reflected many diverse styles of personal recovery.

The Family Recovery Movement

Parents, partners, and children of alcoholics have been involved in service roles in the addiction arena for more than two centuries. Several Native American temperance reformers were children of alcoholics as was Dr. Benjamin Rush--the godfather of American addiction medicine--and large numbers of wives and children of alcoholics sought support and service roles with the 19th century temperance movement. From the Washington Movement through A.A., wives similarly played crucial roles in the history of these mutual aid societies. But it wasn't until the 1970s and 1980s that their presence within American treatment institutions become visible and legitimized. Prior to that period, family members were viewed as a contributing factor in the etiology of addiction, a potential source of sabotage during treatment, or, at the very best, an instrument of support for the alcoholic in treatment (White, 1998).

A whole movement emerged in the 1980s around the ideas that: 1) family members of alcoholics and addicts experienced distortions in their thinking, emotions, and behavior as adaptations to addiction within the family, 2) family members of alcoholics deserved treatment and support for their own recovery, and 3) the movement through the developmental stages of recovery for family members and the family as a whole could be facilitated by mutual sharing and support with others who were in a similar process of recovery. Champions of early family perspectives on addiction (Joan Jackson) gave way to new pioneers (Claudia Black and Sharon Wegscheider-Cruse) and a new genre of family-oriented confessional, self-help and treatment literature.

During the 1980s, the percentage of recovered alcoholics filling direct care roles in addiction treatment programs decreased as the number of recovering family members increased and as the number of academically trained professionals without recovery backgrounds

increased. Recovering family members were especially drawn to work within newly created "family programs"--specialized tracks of family education and treatment that were incorporated into increasing numbers of addiction treatment agencies. By the late 1980s, these tracks evolved into formalized programs for children and adult children of alcoholics which evolved into "codependency" treatment programs. One of the by-products of these transitions was a growing number of women and men working in the field who brought both personal and/or family recovery perspectives to their professional service activities, and affiliation with such groups as Al-Anon and Adult Children of Alcoholics. After more than 150 years as a primarily male field of endeavor, the profession of addiction treatment finally began a process of feminization.

Discussion

To conclude this historical review, we will briefly review: 1) how the status of wounded healers has evolved within the larger history of addiction-related mutual aid and addiction treatment in America, 2) the current status of recovered people working in addiction treatment, and 3) the special assets and vulnerabilities of the wounded healer.

The Evolving Role of the Wounded Healer

There are several major themes within the history we have explored.

From Cultural Reform to Personal Reform It could be argued that the abstinence-based, Native American cultural revitalization movements led by recovered alcoholics do not constitute threads within the tradition of recovered alcoholics working within addiction treatment on the grounds that these groups did not have a singular focus on the problem of alcoholism. It seems likely, however, that the leaders of these movements understood that these structures would have had little relevance if they had been so narrowly defined. Recovery movements that arise within a people under physical and cultural assault must address personal recovery within its most pressing political, economic, and cultural contexts. While the earliest roots of professional helping by recovered people were by necessity enmeshed within broader acts of political advocacy and political/cultural renewal, there is an enduring strain between the impulse to rally against environmental conditions that contribute to excessive drug use, and the impulse to focus on the personal reformation of those who are casualties of that excess.

From Avocation to Vocation Wounded healers have long experienced a strain between an avocation (calling) to work with the addicted and the more formal demands of vocation--the use of one's addiction and recovery experience as a credential for professional employment.

From the Spiritual to the Secular The stories of many of the most noted wounded healers--Handsome Lake, John Gough, John Hawkins, Jerry McAuley, Bill Wilson, Malcolm X--are remarkable, in part, for their dramatic conversion experiences and the messianic visions that drove their subsequent service activities. Emerging movements to help those addicted to alcohol and other drugs often begin in the spiritual arena and then migrate to a secular arena. This can be seen in the movement from Courtenay Baylor's religious approach of lay therapy at the Emmanuel Clinic to the emergence of Richard Peabody's technical approach to lay therapy that was privatized and stripped of its religious and spiritual dimensions. In these transitions, we see a shift from doing things with and for the alcoholic (housing, feeding, listening, sharing, praying) in the context of an equal relationship, to doing things to the alcoholic ("treating") in the context of an unequal, fiduciary relationship. The modern credentialing movement similarly shifted the

focus of the helping process from one that was essentially a spiritual process to one that was rooted in the disciplines of physiology, pharmacology, psychology, and social casework.

From the Personal to the Professional/Technical Throughout the 19th century, recovered alcoholics pursued highly personal activities for the benefit of themselves and others similarly afflicted. The essence of this service to self and others was the sharing of experience, strength and hope through persuasive speaking, personal correspondence, face-to-face consultations with alcoholics and their families, and through telling one's story in books, pamphlets, and such specialized newspapers as *The Reformed Drunkard*. There has been an enduring strain between whether recovered alcoholics should continue to perform these functions or whether they should instead be performing more technical and less personal services. The modern debate about counselor self-disclosure suggests a movement from the personal to the professional/technical.

It is in the lay therapy movement of the Emmanuel Movement that we see the emergence of a defined structure, process, and body of clinical technique that constitutes a specialized psychotherapy for alcoholism. This is the first time we see the recovered alcoholic taking on primary responsibility for the "treatment" of other alcoholics. It is here that we see the functions of the recovered professional helper expand beyond his own storytelling, advice-giving and encouragement. We find here a well-developed theory of the etiology of alcoholism, criteria for the selection of those candidates most likely to be helped, the use of informed consent and confidentiality negotiations, a multi-staged counseling process, well-defined and codified counseling techniques, and literature assigned to the client as an adjunct to the counseling process. It is in the early Peabody-trained lay therapists that we first get the feeling that there is much more involved in counseling an alcoholic than passing along what one learned in the mastery of one's own personal recovery. It is here that we see how the legitimacy of the recovered professional helper evolved from the credential of internally acquired knowledge to a credential of externally mastered knowledge and skill.

From the Public to the Private There are repeated cycles of moving the helping process by recovered people from one wrapped within a larger institutional setting that has broad public support to an activity that is done in isolation and for personal profit. This trend spans the movement of Washingtonian leaders into the professional lecture circuit to the movement of modern addiction counseling into private practice. A hallmark of professionalization--the ability to practice independently--seems to work against the enduring calls for multidisciplinary models for the care of the addicted.

Cyclical Presence The use of recovered people as professional helpers has been continually rediscovered over the past two centuries. The ascension of this practice has often involved recovered people filling a void within a stigmatized arena that attracted only a small number of professionals. The decline in this practice is less clear. We know very little about why inebriate homes and addiction cure institutes moved away from the practice of hiring recovered inebriates just as we know very little about the mid-20th century decline of the lay therapy movement. But three hypotheses are worthy of testing: 1) Problems of sustaining levels of commitment and competence arise as the use of recovered people moves from its pilot (social movement) stage to its replication (professionalization, institutionalization) stage. 2) Recovered people can claim ownership of the addiction problem only when that problem is perceived to have no value to mainstream helping professionals. 3) When the medicalization of addiction enhances the prestige and profitability of those laying claim to this problem, recovered people without traditional academic credentials diminish in number and visibility.

Changing Roles There is a cyclical aspect to the role changes of recovered people. The emergence of recovered people in A.A. working within the early farms, retreats, and eventually within the newly emerging Minnesota Model constitute a reversion to the style of the 19th century temperance reformer. The influence of the lay therapy movement was to a great extent lost as

A.A. members working in the alcoholism field essentially reverted to the functions of sharing their own story, offering encouragement, and offering advice drawn from A.A.'s basic texts. The later strain to professionalize the Minnesota Model resulted in reintegrating many of the lay therapy elements back into the role of alcoholism counselor.

The Modern Transition What alcoholism counselors had in the social movement phase of treatment was a deep, experiential understanding of the stakes involved in addiction treatment. Counselors understood that there was a life or death quality to their work. They saw the whole alcoholic and the entire outcome of treatment--at its best and its worst. In what has become a much more fragmented and clinically antiseptic field, today's counselors work with addicts that somebody else sobered up, and they work with them for a narrow slice of time, knowing little of what came before or what follows. Many (if not most) of today's counselors have never seen Delirium Tremens (DTs), never seen heroin withdrawal face-toface, never held the hand of an addict dying from addiction-related diseases, never stood beside family members over the graves of alcoholics and addicts who didn't make it. The knowledge base of counseling has moved from an emphasis on an experiential understanding of the process of addiction and recovery--its physiology, its psychology, its spirituality, its geography and sociology--to an emphasis on what is for many of today's addiction counselors essentially hearsay knowledge. Those systems that have helped recovered addicts acquire education and professional credentials have sustained a valuable blend of firsthand and secondhand knowledge.

From Community to Career Addiction counselors of yesteryear had a sense that they and their clients were part of a larger family or community. The relationships between counselors and their clients have become much more professionally encapsulated and more emotionally detached. Viewed nationally, the relationships between counselors and the recovering community have evaporated. Counselors of yesteryear, like their clients, had an umbilical cord attached to the recovery community that linked them, fed them, nurtured them. The number of today's counselors who have never been (or not been in years) to an A.A., Al-Anon, NA, CA, WFS, SOS, RR, or MM meeting or who do not see themselves as being part of this larger community would be incomprehensible by the standards of yesteryear. In the face of such disconnection, today's counselors must seek other sources of strength from which they can convey a hope to the alcoholics and addicts sitting across from them. Where such sources are not found or consistently tapped, hope may be a diminishing element within a treatment milieu.

Support Then and Now The conditions under which recovered people have pursued their service roles have changed significantly. Recovered people today enter the enterprise of addiction treatment having often have had their own addiction careers interrupted at earlier stages. They bring longer periods of sobriety before entering the work and greater access to sobriety-based support groups to sustain their own recovery process. They have received considerable education and training before they begin counseling others. They are more likely, than their 19th and early 20th century counterparts, to be imbedded within a large interdisciplinary team and have greater access to clinical supervision. These conditions provide a greater level of preparation and support than has been available during any earlier period of American history.

Lost Dimensions In reviewing the evolution of this wounded healer role, it is perhaps appropriate to ask whether anything of value has been lost within the many transitions in this role. If addiction counseling were represented metaphorically as an onion, we have added layer upon layer to this role while some believe that we have come to neglect the core. There is almost universal concern that, in our preoccupation with documentation, billing, scheduling, and all of the other mechanisms that surround the counseling process, we have forgotten the empathic relationship that is the core of this process. It is the recovered person who has most consistently brought this capacity for empathy to the engagement of addicts and their families. Their professionalization and declining numbers might reflect a diminishing emphasis in modern treatment on this most fundamental foundation of addiction counseling.

The medically and psychologically derived therapeutic models in which recovered alcoholics and addicts are trained as part of their transition into the profession of addiction counseling has limitations as well as value. By over-identifying with this new body of knowledge, the recovered person may refute the value and legitimacy of their own experience in ways that diminish their empathy and connectedness to the still suffering alcoholics/addicts who seek their services (Kite and Keyes, 1973, p. 79-80). Emotional detachment in the name of professionalism may neutralize the most important assets the recovered person brings to the field of addiction treatment. When this happens on a large scale, then the question of the future of recovered people working in the field will have been rendered irrelevant because all clinically important differences between counselors with and without recovery backgrounds will have dissipated.

Current Status of Recovered Professionals

Studies of the addiction treatment workforce have found different percentages of direct care staff in recovery at different times and within different treatment modalities. The percentage of those with a recovery background who work as addiction counselors has been reported as low as 7% in community mental health centers and 14% in inpatient VA programs; as ranging from 35-40% in methadone and outpatient drug free programs; and as high as 70-75% in private inpatient programs, detoxification programs, and halfway houses (Humphreys, Noke and Moose, 1996; Aiken, et.al., 1985; Mulligan, et.al., 1989). Over half of certified addictions counselors surveyed nationally acknowledge recovery status (Birch and Davis, 1983, 57%; McGovern, 1987, 70%; NAADAC, 1993, 63%; NAADAC, 1995, 58%; Roman and Blum, 1997, 62%).

These studies suggest that the percentage of recovered people working in the field peaked at between 70-80% between 1985-1990 and then slowly declined to the 50-60% range in the 1990s. Given the lower use of recovered people in community mental health centers and independent health care systems like the VA, this percentage will likely continue to decline if the treatment of addiction to alcohol and other drugs continues to move from a segregated system to integration within broader behavioral health service systems.

Assets and Vulnerabilities of Wounded Healers

Several efforts have been made to delineate the characteristics of those with and without recovery backgrounds who work in the addictions treatment field (Anderson, 1944, 1950; Blume, 1977; Bissell, 1982; McGovern and Armstrong, 1987; White, 1979, 1998). These collective observations suggest eight assets that recovered people have brought to their roles in addiction treatment institutions in America: 1) a knowledge of the physiology, psychology, and culture of addiction that is derived from direct experience; 2) a capacity for, and openness to, emotional identification (kinship) with the addict; 3) an absence of condescension and contempt derived from an equality of shared experience and vulnerability; 4) a zeal (calling) to heal others that flows out of a deep sense of personal gratitude for their own recovery; 5) the ability to use their own stories to incite hope in the potential for recovery; 6) a willingness to be more directive (than traditionally trained helping professionals) when counseling alcoholics in the earliest stages of recovery; 7) the capacity to serve as a role model for the client and to coach the client on day-to-day issues faced in early recovery; and 8) the ability to provide clients with a detailed and personal orientation to A.A. and other mutual aid societies.

At the same time, the professional helper in personal recovery may be prone to: 1) experience interprofessional conflicts arising from differing views about the nature of addiction and recovery as well as from their own unresolved feelings about past maltreatment by professionals, 2) overextend themselves to compensate for their self-perceived lack of credentials, 3) experience special problems of countertransference with clients, e.g., trying to

program a client's recovery within the framework of his or her own recovery, 4) develop a dependency upon the social and emotional intensity of the work milieu to meet unmet social and intimacy needs, 6) experience role confusion and role conflict between mutual support group activities and professional counseling activities, and 7) to experience a rare, but quite real, vulnerability for relapse.

There are two points that should be made regarding this catalogue of assets and vulnerabilities of professional helpers in personal recovery. The first is that assets and vulnerabilities are often closely linked regardless of one's recovery status. The recovered person's capacity for identification has a shadow side (the vulnerability for over-identification), just as the objectivity and clear professional boundaries that are the alleged hallmark of the academically-trained professional helper can evolve into emotional detachment and clinical abandonment. Every experience or trait that can add to the helping process, when pushed to excess, reveals a shadow side (Ottenberg, 1977). A second point is that assets and vulnerabilities applied to such categories as "recovered" or "non-recovered" may not hold up under the scrutiny of science. For example, the idea that recovered staff as a group hold either certain beliefs or rigid beliefs about addiction, treatment and recovery has been challenged in research comparing staff with and without recovery backgrounds. For example, recovered staff in one major study were less likely than other staff to see alcoholics as an homogenous group whose needs could be met within a single approach to treatment (Humphreys, Noke and Moose, 1996).

Personal Recovery as a Professional Credential

A personal history of recovery from addiction does not, *in and of itself*, qualify or disqualify one as an effective facilitator of recovery for others. Modern studies have confirmed that the presence or lack of personal recovery are not predictors of counseling effectiveness or ineffectiveness (Covner, 1969; Rosenberg, et.al., 1976; Allison and Hubbard, 1985). Only one study noted superior treatment outcomes for patients assigned recovered counselors and that gain was only for younger (under age 35) patients (Argeriou and Manohar, 1978). Individual counselor beliefs and practices often thought to be defined by recovery or non-recovery status often are frequently found in research studies to be shaped instead by such factors as age, years of education, or treatment setting (Berger-Gross and Lisman, 1979; Shipko and Stout, 1992).

In recounting the power of the wounded healer in the history of addiction treatment, one must be careful not to romanticize the pain of addiction. Such pain is more naturally debasing than ennobling. There is nothing in the addict's injured and fouled body, oft-profane tongue, or emotional/physical cruelties that stands as a qualification to help others. The personal experience of addiction takes on value only in the context of recovery. For every wounded healer carrying a message of hope today, there are a thousand addicts whose wounds were mortal. The lessons to be learned from the wounding become available to others only within the context of enduring recovery. And yet, even the most remarkable recovery from addiction may not, by itself, render one capable of working effectively as an addictions counselor. The best addiction counselors are often described by a constellation of traits-compassion, empathy, respect, genuineness, emotional courage--that cannot be easily reduced to categories of life experience or formal education.

A Closing Reflection

There are many things in this history worthy of emulation. If we look at the most notable of the recovered people within this history, we find a sense of personal calling and a vision of how that calling can unfold within a particular historical context. We find a profound belief that working with addicts and their families is a worthy and noble way to spend one's life. We find a

purity and singleness of purpose. We find in this story people who enter relationships with alcoholics and addicts from a position of moral equality, lacking the contempt and condescension that has long marred the relationship between addicts and their would-be professional helpers. We find a style of influence that is based more on life experience couched in story than in theory or rational argument. There is perhaps most of all an authenticity of emotional contact--an empathic understanding of the deforming powers of addiction and a passionate belief in the healing power of recovery. Recovered people, with all their assets and vulnerabilities, enter relationships with their clients with an unshakable belief that there is hope for permanent recovery from addiction, the best evidence of which lies within their own transformed lives.

So how does one emulate such qualities? If we look at those without personal addiction recovery experience who have been universally acknowledged for their special skills in working with alcoholics and addicts, we do find that they are individuals who have, like the alcoholic and addict, faced their own stark limitations, emptied themselves out, and experienced their own rebirth (Kurtz, 1996/1999). Concepts like “wounded healer” and “kinship of common suffering” transcend such labels as alcoholic and non-alcoholic. While the mechanism of addict-addict identification has long been a dimension of recovery for many people, what may be most important in the professional arena, is this authenticity of emotional contact that provides the context for the technical skills one offers as a professional helper. Such empathy and authenticity transcend the issue of one’s recovery status.

A final lesson that can be drawn from those in recovery is the personal vulnerability that is inherent within the process of relating out of such emotional authenticity. Some of the most notable figures in this history--from John Gough to Jerry McAuley to Marty Mann, experienced brief relapses during their service careers while others had their careers (and their lives) destroyed by such falls from grace. Recognizing the kinds of daily activities that have long helped recovered people sustain their recoveries and their health working in this field can offer guidance for us all. Those activities include: 1) centering rituals that provide an opportunity for self-reflection and re-focus, 2) mirroring rituals that bring us together with kindred spirits for refreshment and re-commitment, 3) acts of selfresponsibility and self-repair that allow us to make sure that our own home is not left in darkness while we carry light to others, and 4) private, unpaid acts of service that serve to rekindle the values and commitments that first drew us to this work.

Historically, recovered and recovering people brought great passion and energy to the treatment milieu. They brought a focus on direct service to the still suffering addict and a deep faith in the potential for recovery derived from their own transformed lives and their participation in a community of recovered and recovering people. It is that contagious spirit of hope that must not be lost as this field enters a new century.

References

Aiken, L., LoSciuto, L. and Ausetts, M. (1985). Who is Serving Drug Abuse Clients. In: Ashery, R. Ed., *Progress in the development of Cost-effective Treatment for Drug Abusers*. Rockville, MD: NIDA (NIDA Research Monograph 58).

Alcoholics Anonymous (1970). *Final Report, Twentieth Annual Meeting of the General Service Conference of Alcoholics Anonymous*. New York: General Service Office of Alcoholics Anonymous.

Alcoholics Anonymous (1975). *Final Report, Twenty-Fifth Annual Meeting of the General Service Conference of Alcoholics Anonymous*. New York: General Service Office of Alcoholics Anonymous.

Anderson, B. and Blankman, B. (1986). Impaired Counselors: A National Survey. *The Counselor,* 4(5):18-19.

Anderson, D. (1944). The Place of the Lay Therapist in the Treatment of Alcoholics. *Quarterly Journal of Studies on Alcohol*, (September), pp. 257266.

Allison, M. And Hubbard, R. (1985). Drug Abuse Treatment Process: A Review of the Literature. *International Journal of the Addictions,* 20: 1321-1345.

Argeriou, M. and Monohar, V. (1978) Relative Effectiveness of Non-alcoholics and Recovered Alcoholics as Counselors. *Journal of Studies on Alcohol* 39:793700.

Berger-Gross, V., and Lisman, S. (1979) Attitudes of Paraprofessionals toward Alcoholism: Settings Effects. *Journal of Study on Alcohol* 40:514-517.

Birch & Davis Associates (1983). *Development of Model Professional Standards for Counselor Credentialing*. Rockville, MD: NIAAA.

Bissell, L. (1982). Recovered Alcoholic Counselors. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism.* New York: Gardner Press, pp. 810-817.

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*. New York: Plenum Press, pp. 545-565.

Briggs, D. (1963) Convicted Felons as Social Therapists. *Correctional Psychiatry and Journal of Social Therapy* 9:122-126.

Camp, J. and Kurtz, N. (1982) Redirecting Manpower for Alcoholism Treatment. In: Prevention, Intervention and Treatment: Concerns and Models. Alcohol and Health Monograph, No. 3, pp. 371-397. (DHHS Publication No. ADM 82-1192) Washington, D.C.: U.S. Government Printing.

Carkhuff, R. and Truax, C. (1965) Lay Mental Health Counseling: The Effects of Lay Group Counseling. *Journal of Counseling Psychology* 29:426-431.

Carkhuff, R. (1969) *Helping and Human Relationships: A Primer for Lay and Professional Helpers*. New York: Rinehart & Winston.

Carkhuff, R. (1971) *The Development of Human Resources: Education, Psychology, and Social Change*. New York: Holt and Rinehart.

Covner, B. (1969) Screening Volunteer Alcoholism Counselors. *Quarterly Journal of Studies on Alcohol* 30:420425.

Davis, C. and Ford, C. (1980). *Preparing a Drug Abuse Workforce: A National Training System.* Washington, C.C.: Career Development Center.

The Fifth ATwo Hatter@... (1981) *Alcoholism Report*, February 27, 1981, p. 7.

Grosser, C., Henry, W., and Kelley, J. (1969) *Nonprofessionals in the Human Services*. San Francisco: Josey-Bass.

Humphreys, K., Noke, J., and Moos, R. (1996). Recovering Substance Abuse Staff Members' Beliefs About Addiction. *Journal of Substance Abuse Treatment* 13(1):75-78.

Kinney, J. (1983). Relapse Among Alcoholics Who Are Alcoholism Counselors. *Journal of Studies on Alcohol,* 44(4): 744-748.

Kite, R. and Keyes, R. (1973). The Para-Professional in the Poverty Community. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: Illinois: Charles C. Thomas Publisher, pp.78-84.

Kolpack, R. (1992) Credentialing Alcoholism Counselors. *Alcoholism Treatment Quarterly* 9:97-112.

Krystal, H. and Moore, R. (1963). Who is Qualified to Treat the Alcoholic? *Quarterly Journal of Studies on Alcohol*, 27:449-59.

Kurtz, E. (1996). Spirituality and the Secular Quest: Twelve Step Programs. In: *World Spirituality Encyclopedic History of the Religious Quest*, Vol 22, Ed. Peter Can Ness, NY: Crossroad. (Also in Kurtz, E. (1999) *The Collected Ernie Kurtz*. Wheeling, West Virginia: The Bishop of Books, pp.145-176).

Lisnow, F. (1989). Is Impairment a Current Issue Facing Alcoholism and Drug Abuse Counselors? *The Counselor* 7(4):18-19, 42.

McGovern, T. (1986). Our Professional Identity, Birth, Infancy, and Adolescence of our Profession. *The Counselor,* 4(4), 7-9, 30.

McGovern, T. and Armstrong, D. (1987). Comparison of Recovering and NonAlcoholic Counselors: A Survey. *Alcoholism Treatment Quarterly*, 4(1):4360.

McGovern, T. (1992). Alcoholism and Drug Abuse Counseling: A Personal Reflection. *The Counselor*, 10(3):38-46.

McInerney, J. (1973). Alcoholics Anonymous Members as Alcoholism Counselors. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: Illinois: Charles C. Thomas Publisher, pp. 91-105.

Mitchell, L. (1981). Credentialing and Certification of Drug Abuse Workers: A Review and State of the Art Report. In: Lowinson, J. and Ruiz, P. *Substance Abuse: Clinical Problems and Perspectives*. Baltimore: Williams & Wilkins, pp. 830-839.

Mulligan, D., McCarty, D., Potter, S., and Krakow, M. (1989). Counselors in Public and Private Alcoholism and Drug Abuse Treatment Programs. *Alcoholism Treatment Quarterly* 6(3/4):75-89.

NAADAC Education and Research Foundation (1993). *Salary and Compensation study of Alcoholism and Drug Abuse Professionals*. Arlington, VA.

NAADAC Education and Research Foundation (1995). *Salary and Compensation study of Alcoholism and Drug Abuse Professionals*. Arlington, VA.

Norris, J. (1970). The Hazards of A.A.=s Counseling for Pay. *A.A. Grapevine*, October, pp. 2-3.

Of the 475 physicians... (1978). *Alcoholism Report* 6(15):8.

Ottenberg, D. (1977) Traditional and Nontraditional Credentials in Addictive ProblemsBA Dispatch from the Battlefield. *The Addiction Therapist* 2(1)(Winter):56-63.

Over 200...Community Action Poverty Programs (1972). *The Alcoholism Report*. 1(2):6, November 10.

Pattison, E. (1973). A Differential View of Manpower Resources. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: Illinois: Charles C. Thomas Publisher, pp. 9-31.

Reiff, R. and Reissman, F. (1970) The Indigenous Nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

Roman, P. and Blum, T. (1997). *National Treatment Center Study: Summary Report*. Athens, GA: Institute for Behavioral Health.

Rosenberg, C., Gerrein, J, Manohar, V., and Liftik, J. (1976) Evaluation of Training of Alcoholism Counselors. *Journal of Studies on Alcohol* 37:1236-1246.

Rosenberg, C. (1982). The Para-professional in Alcoholism Treatment. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism*. New York: Gardner Press, pp. 802-809.

Roy Littlejohn Associates, Inc. (1974) *Competencies of an Alcoholism Counselor: Proposed National Standards for Alcoholism Counselors. Final Report*. National Institute on Alcohol Abuse and Alcoholism.

Schmidt, L. (1993). Private Practice: Wave of the Future? *The Counselor* Sep/Oct, pp. 25-29.

Schulstad, M. (1998). Transcribed Personal Interviews, July 2 and July 17.

Senay, E. (1981). Multi-modality Programming in Illinois: Evolution of a Public Health Concept. In: Lowinson, J. and Ruiz, P. (Eds.). *Substance Abuse: Clinical Problems and Perspectives* Baltimore, Maryland: Williams & Wilkins, pp. 396-402.

Senay, E. (1989). Drug Abuse treatment in Illinois, 1966-1984. In: Arif, A. and Westermeyer, J. Eds. *Methadone in the Maintenance of Opioid Dependence: Programs and Policies Around the World.* New York: Praeger, 216-226.

Shipko, J. and Stout,, C. (1992) A Comparison of the Personality Characteristics Between the Recovering Alcoholic and non-alcoholic counselor. *Alcoholism Treatment Quarterly* 9:207-214.

Spicer, J. (1993). *The Minnesota Model: The Evolution of the Interdisciplinary Approach to Addiction Recovery.* Center City, Minnesota: Hazelden Educational Materials.
Valle, S. (1979). *Alcoholism Counseling: Issues for an Emerging Profession* Springfield, IL: Charles C. Thomas.
Valle, S. (1983) Alcohol/Drug Counselor Credentialing Movement Changing the Profile of Health Care Delivery*. The U.S. Journal of Drug and Alcohol Dependence*. 7(2):1-4.
White, W. (1979). *Relapse as a Phenomenon of Staff Burnout in Recovering Substance Abusers Working as Counselors*. Rockville, MD: HCS, Inc.
White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.
Wilson, D. (1984). Impaired Counselor: The Ignored Problem of the New Profession. *The Counselor*, July/August, p. 5.



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. (2000). Toward a new recovery advocacy movement. Posted at **www.williamwhitepapers.com**

Toward a New Recovery Advocacy Movement:

Historical Reflections on Recovery, Treatment and Advocacy[1]

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Preface

As a new recovery advocacy movement struggles to be born, many search for the midwife who can protect the Sources from whose loins this movement is emerging while helping this movement seek its own life and destiny. I believe history can serve as that midwife.

I have lived and worked in the worlds of addiction treatment and recovery for more than three decades--all of my adult life, and it was my experiences in these worlds that first incited my fascination with history and my discovery of history as the ultimate elder. For many years, I have sat at history's feet, listened to her stories, and tried to be an ardent student. The following pages are filled with my, admittedly inadequate, comprehension of the lessons that I believe history can offer this new recovery movement. These ideas were first presented at CSAT's Recovery Community Support Program Conference in April, 2000 and are here expanded in the hopes of aiding recovery organizations across the country.

Bill White

Bloomington, Illinois

August 8, 2000

[1]Acknowledgment: I am deeply indebted to the many questions raised and suggestions offered by Dr. Ernest Kurtz on the issues explored in this paper. That our discussions created a far better product than I could have produced alone is perhaps an apt testament to a paper that is, at heart, about the power of community.

Table of Contents

1.0 Recovery in America: A Brief Synopsis 6

2.0 Toward a Recovery Movement 7

2.1 Alcoholism Movement, Treatment Movement, Recovery Movement 7

2.2 Multiple Movements 8

2.3 Recovery Community and Recovery Movement 8

2.4 Movement Goals 9

2.5 Distinguishing Treatment and Recovery 10

2.6 Distinguishing Mutual Aid, Treatment, and Advocacy 11

2.7 Cultural Revitalization 11

2.8 Concepts that “Work” 12

2.9 New Kinetic Ideas 12

2.9.1 Addiction recovery is a reality. 13

2.9.2 There are many paths to recovery. 13

2.9.3 Recovery flourishes in supportive communities. 14

2.9.4 Recovery is a voluntary process. 15

2.9.5 Recovering and recovered people are part of the solution. 15

2.10 The Cost of Recovery 16

2.11 Redefining Recovery 16

2.12 Models of Social Change 17

2.13 Core Activities 17

2.14 Toward Realistic Images 18

2.15 Accurate, Hopeful Language 18

2.16 Transforming Existing Social Institutions 19

2.17 Movement Scope 20
3.0 Movement Pitfalls 20
3.1 Professionalization and Commercialization 20
3.2 Money and Movements 21
3.3 Lost Stewardship 22
3.4 Self-destruction by Implosion or Absorption 22
3.5 Premature Victory 22
3.6 Mission Diffusion 23
3.7 Methods and Mission 23
3.8 Stigma Close to Home 24
3.9 Scapegoating: Inclusion/Exclusion 24
3.10 Those Left Behind 24
3.11 Movement Coalitions 25
3.12 Developmental Stages 25
3.13 Movement Stages and Movement Roles 26
3.14 Member Attrition 26
3.15 Counter-movements 26
3.16 Defining Moments 27
4.0 The Recovery Research Agenda 27
4.1 Technological Advances 27
4.2 The Recovery Research Agenda 27
5.0 Leadership 29
5.1 Source of Movement Leadership 29
5.2 The Problem of Centralized, Charismatic Leadership 29
5.3 Personal Price of Leadership 30

5.4 The Vulnerability of Leaders (The Curse of Icarus) 30
5.5 Media and Leadership 30
5.6 Leadership Development and Succession 30
6.0 Pleasures and Pitfalls of Movement Participation 31
6.1 The Nobility of Service 31
6.2 Movement Participation 31
6.3 Message and Messenger 31
6.4 Movement Demands/Strains 31
6.5 The Primacy of Personal Recovery 32
6.5.1 Centering Rituals 32
6.5.2 Mirroring Rituals 32
6.5.3 Acts of Personal Responsibility 32
6.5.4 Unpaid Acts of Unrelated Service 33
6.6 The Potential Enormity of an Individual Life 33
7.0 Summary 33
References 34

Toward a New Recovery Movement:

Historical Reflections on Recovery, Treatment and Advocacy

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

> Twenty-eight African-American ministers are meeting today to discuss using the combined resources of their churches to launch a local faith-based addiction recovery program aimed at salvaging the lives of individuals and families being destroyed by alcohol and other drugs. The ministers are deeply concerned that many members of their community have not done well in traditional treatment or mutual aid groups.
>
> The Circles of Recovery program (of White Bison, Inc. in Colorado Springs, Colorado) uses thirty tribal colleges to train individuals in recovery ("Firestarters") to seed cultures of recovery within Native American communities.
>
> The Connecticut Community for Addiction Recovery has organized recovering people and their families to help educate communities about recovery, to advocate for improved quality of addiction treatment, and to provide a wide range of recovery support services.
>
> Every Saturday, 20 young men in recovery from addiction wearing T-shirts that read, "Ambassadors of Recovery" clean up neighborhood parks, replace graffiti with uplifting art, and talk with neighborhood youngsters. They consider these service activities a way to make restitution for the wounds they afflicted on their community when they were addicted.

These local stories are part of a larger story: recovering people across the United States joining together to achieve goals that transcend their mutual support needs. Collectively, these communities without boundaries are expanding local recovery support services, advocating for the needs of addicted and recovering people, and finding creative ways to make amends and carry hope to others. The purpose of this paper is to acknowledge the existence of this new recovery movement, and to tap lessons from the history of addiction recovery, treatment and advocacy in America that might guide and protect this movement.

1.0 Recovery Advocacy in America: A Brief Synopsis

To begin, the history we will use to illuminate this new recovery movement is a deep one. For more than two centuries, recovering people and their families have been at the forefront of efforts to organize or sustain addiction-related mutual aid societies, religiously and medically-focused treatment institutions, and a wide variety of alcohol/drug-related advocacy groups in America.

The history of addiction mutual aid societies spans:

- 18th century Native American recovery "circles"
- 19th century alcoholic mutual aid societies (the Washingtonians, the fraternal temperance societies, the ribbon reform clubs, the Godwin Association, the Ollapod Club, the Keeley Leagues, and various moderation societies)
- early 20th century alcoholic mutual aid societies (The United Order of Ex-Boozers, the Jacoby Club)
- Alcoholics Anonymous, Al-Anon, Narcotics Anonymous and other 12-Step addiction recovery groups, and
- a plethora of post-AA mutual aid societies (Alcoholics Victorious, Women for Sobriety, Secular Organization for Sobriety, and Moderation Management, to name only a few). (White, 2000 a,b,c).

There is a similarly long history of addiction treatment in the United States. Such treatment began within the private physician practices of the late 18th and early 19th centuries. By the late 19th century, there was a multi-branched treatment movement made up of:

- religiously-oriented inebriate homes
- medically-oriented inebriate asylums
- for-profit private addiction cure institutes, and
- bottled home cures for the alcohol, drug and tobacco "habits."

Following the virtual collapse of the specialized field of addiction treatment in the opening decades of the 20th century, treatment institutions again emerged during the middle decades of the 20th century (White, 1998).

Social, political and religious advocacy regarding alcohol other drug-related problems first focused on the problem of public intoxication (Austin, 1979; Lender and Martin, 1982). Advocacy efforts evolved into a concern about alcohol and other drug

addictions in the 19th century (Levine, 1974), and culminated in parallel alcohol and other drug prohibition movements that reached a crescendo in the second decade of the 20th century (Sinclair, 1962; Musto, 1973). In the Post-Repeal years, alcohol and other drug (AOD)-related advocacy movements have varied greatly in the:

1) drugs they targeted,

2) population of users with whom they were most concerned,

3) particular drinking or drug using behavior that was their primary focus of attention, and

4) overall goals.

Such movements have included victim/survivor groups (MADD), drug prohibition and legalization movements, and a broad spectrum of prevention-oriented movements. Advocacy specifically related to addiction treatment and recovery began anew in the 1940s.

Between 1940 and 1970, a multi-factioned "modern alcoholism movement" sought and partially achieved a dramatic change in how the nation perceived alcoholism and the alcoholic. The grass roots nature of this movement dissipated as an alcoholism industry (and by extension, addiction industry) emerged and then became highly professionalized and commercialized. The 1990s witnessed a financial and ideological backlash against this industry and a new century opens with many believing that the ground gained in the mid-20th century is being lost in the face of a growing demedicalization, restimgatization and recriminalization of addiction.

The evidence of this shift can be seen in the:

- growing frequency and stridency of attacks on the disease concept of addiction and Alcoholics Anonymous,
- erosion of funding for addiction treatment,
- closure and/or dramatic downsizing of most hospital-based and (many) private addiction treatment units, and the
- virtual explosion in the number of alcoholics and addicts who, once cared for in the public health arena, are now being controlled within the criminal justice arena.

In the midst of growing pessimism in the American culture about the prospects of recovery, there is a growing call for a new, grassroots recovery advocacy. This movement is re-raising questions about the potentials and pitfalls in the interrelationship

between recovering people, mutual aid organizations, treatment institutions, and public education and social advocacy agencies.

2.0 Toward a Recovery Movement

2.1 Alcoholism Movement, Treatment Movement, Recovery Movement The modern alcoholism movement focused on educating the public and professionals on the nature of alcoholism and the character of the alcoholic. The treatment movement that grew out of it focused on creating, professionalizing and legitimizing medically- and psychologically-oriented care of the alcoholic and the addict. While each of these movements can claim successes, the dissipation of the first movement and a backlash against the second has left a vacuum that begs to be filled. *It is time for a recovery movement. The central message of this new movement is not that "alcoholism is a disease" or that "treatment works" but rather that permanent recovery from alcohol and other drug-related problems is not only possible but a reality in the lives of hundreds of thousands of individuals and families.*

In our enduring debate over whether the roots of addiction lie in the medical arena (a problem of susceptibility) or the moral arena (a problem of culpability), we have lost touch with real solutions to addiction, the evidence of which is in the transformed lives of recovering and recovered people across America. Demonstrated solutions to alcohol and drug problems will do more to reduce the stigma attached to these conditions than will endless debates about the source of such problems. The question of the etiology and nature of addiction is a scientific question, not one resolved by social policy proclamation. The focus of this new movement is not on the source or nature of addiction, nor on the solutions that science may provide tomorrow. Instead, the focus is on the solutions that are possible at this moment if resources can be mobilized to effectuate them. *It is time we (the remnants of the existing alcoholism/treatment movements) redirected our energies from an emphasis on pathology to an emphasis on resilience and recovery.*

2.2 Multiple Movements There is accumulating evidence of two new emerging and potentially complimentary movements:

1) a recovery movement that is affirming the very real potential for permanent personal resolution of alcohol and other drug (AOD) problems, and
2) a public health movement that is offering solutions to AOD problems at the community and cultural levels.

While this paper focuses on the recovery movement, both movements are essential for the long-term prevention and management of AOD problems.

2.3 Recovery Community and Recovery Movement *The "recovery community" is a voluntary association of those impacted by AOD problems who come together for mutual support and joint action on AOD-related issues.* A "recovery community" exists only to the extent that multiple and diverse recovery communities reach beyond their own geographical and cultural boundaries to embrace a single identity. *The recovery movement is an organized effort to: 1) remove barriers to recovery for those still suffering from AOD problems, and 2) to improve the quality of life of those recovering from AOD problems*.

References to a recovery community and a recovery movement reflect a sense of identification that goes beyond one alcoholic sharing with another. It is the recognition of the existence of an invisible society without boundaries--a society in which citizenship is granted by the status of shared experience and vulnerability. What the recovery movement offers through its leaders call for mutual aid, social communion, and political advocacy is a siren call of redemptive "we-ness" to those who have been shamed into isolation or cloistered within subterranean subcultures. The recovery movement offers an emboldened challenge to members of the recovering community who have achieved recovery from addiction and are passing as 'civilians' within the larger culture: "It is time we came out of hiding; it is time we announced our presence; it is time that our collective silence was broken." The expectation is not that all or even a majority of persons will go public with their recovery story, but that a sufficient number will choose to do so and that this choice will widen the doorway of entry to recovery for those who are still suffering.

2.4 Movement Goals *The internal goals of the recovery movement include:*

1) portraying alcoholism and addictions as problems for which there are viable and varied recovery solutions,

2) providing living role models that illustrate the diversity of those recovery solutions,

3) countering any public attempt to dehumanize, objectify and demonize those with AOD problems,

4) enhancing the variety, availability, and quality of local/regional treatment and recovery support services, and

5) removing environmental barriers to recovery, including the promotion of laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems.

The modern alcoholism movement focused on changing what people believed: their perceptions and attitudes toward alcoholics. Its focus was on reducing stigma. Movement leadership believed that improved care for the alcoholic would inevitably flow from the removal of such stigma. For the new recovery movement, reducing stigma may be best viewed as a peripheral by-product rather than a central goal of the movement. The goals instead would be best focused on what we want people (represented collectively as communities, states and the nation) to do. Such goals might include advocacy to:

- stop punishing and incarcerating people for what is essentially their status as addicts,
- create physical and psychological space in communities where recovery can occur,
- support research that will contribute to improved recovery outcomes, and
- remove barriers of discrimination against, and enhance opportunities for, recovering people seeking to re-enter productive roles in their communities.

2.5 Distinguishing Treatment and Recovery There are enormous differences between professionally-directed treatment institutions and mutual aid societies, just as there are enormous differences in what constitutes “treatment” and what constitutes “recovery.” A corollary of the proclamation that recovery is a reality is the recognition that professionally-directed addiction treatment may or may not be a factor in such recoveries and, where treatment does play a role, it is an important but quite time-proscribed part of the larger, more complex, and more enduring process of recovery. Treatment was birthed as an adjunct to recovery, but, as treatment grew in size and status, it defined recovery as an adjunct of itself. The original perspective needs to be recaptured. Treatment institutions need to once again become servants of the larger recovery process and the community in which that recovery is nested and sustained. *Treatment is best considered, not as the first line of response to addiction, but a final safety net to help heal the community’s most incapacitated members. The first avenue for problem resolution should be structures that are natural, local, non-hierarchical and non-commercialized*.

The interests and agendas of the recovery community and the treatment field overlap but are not the same. Strong, highly organized constituencies of recovering people are not necessarily in the best interests of professionally-directed treatment

institutions. Recovery constituencies are as likely to be critics as they are supporters of institution-based treatment. Members of recovery advocacy group, perhaps more than anyone, know the excesses and inadequacies of treatment institutions. Recovery advocacy groups will demand that the relationship between treatment professionals and their clients shift from its traditional hierarchical nature to that of a more respectful partnership in which clients have significantly enhanced rights and powers. Recovery advocacy groups will demand that the voices of addicted and recovering people be heard by treatment professionals and not discounted as "their diseases talking." These groups will advocate that treatment become more accessible, affordable, family-centered and effective, and they will confront exploitive or disrespectful treatment practices. The respective interests of the recovery movement and the treatment movement will also create tension over the question of whether resources should be allocated for treatment services or allocated for a broader range of recovery support services.

Recovery support services are services aimed at removing barriers and opening natural pathways to addiction recovery. Such services include transitional housing, recovery homes, day care to increase access to support meetings, sobriety-conducive employment, educational access, debt management and budget counseling, sober fellowship, as well as traditionally defined treatment services. The overall goals are to remove barriers to recovery and to create positive space (sober sanctuary) where recovery can grow. *Professionally-directed treatment services are not the same as the broader umbrella of recovery support services. Indigenous people who lack professional training should not be involved in the former, while the latter may be best designed and delivered by the recovery community. Those providing treatment services and those providing recovery support services play different but complementary roles in the long-term recovery process.*

2.6 Distinguishing Mutual Aid, Treatment and Advocacy Mutual support, professional treatment and social advocacy constitute different but related functions. Mutual aid and treatment seek the transformation of the individual and the family, either within indigenous or professionalized support structures; advocacy seeks the transformation of the community environment.

The recovery community is one in which service is highly valued--one in which the stability of one's own sobriety is measured not by what one possesses but by what one gives away. Advocacy for recovering people is like making a 12th step call on a whole community or culture. It is a way to move recovery from the level of personal redemption to the level of social justice--a way of carrying experience, strength and hope to a whole community. The focus of advocacy is to assure that the cultural forces

inhibiting addiction and promoting recovery outweigh those conditions within which addiction flourishes.

The functions of social advocacy and mutual aid rarely co-exist successfully within the same organization. Addiction recovery mutual aid societies have been mortally wounded by their involvement in operating treatment institutions or becoming ensnared in the political and, sometimes, religious conflict that often surrounds policy advocacy movements. The Washingtonians (1840s), the fraternal temperance societies (mid-1800s) and the reform clubs (1870s-1880s) are merely the earliest examples of the risk of such disruptive influences. When mutual aid groups get involved in broad public policy debates, they face two threats: 1) being torn apart by ideological schisms, and 2) being hijacked by larger, more powerful institutions or movements. *Co-mingling mutual aid and policy advocacy functions usually creates an organization that will either perform both functions poorly or sacrifice one function for the other. It is usually best to separate the service functions of mutual support, professionally-directed treatment, and social policy advocacy into separate agencies (or at least separate organizational units), but there are exceptions to this rule.*

2.7 Cultural Revitalization *For a besieged people (community), personal recovery may be inseparable from the broader issues of social policy advocacy and cultural revitalization.* Colonization, cultural dispossession and the resulting social, family, and personal disorganization heighten vulnerability for AOD problems. Cultural revitalization and cultural repossession provide an antidote to such disorganization and a potential pathway out of addiction. Where viable, indigenous spiritual and healing practices and cultural prescriptions for abstinence need to be embraced within the larger umbrella of recovery support services. (See Williams, 1992 for a vivid example of such indigenous resources in one African-American community.)

Within disempowered communities, addiction and recovery may need to be framed in their political, economic and cultural contexts. Here, one's recovery is more than a personal act and may need to personally and culturally understood as such. Organizations advocating only a political framework of recovery (e.g., depictions of alcohol as a tool of genocide and recovery as a refusal to participate in that genocide), however, have rarely been able to sustain themselves over time, and their members themselves have been quite vulnerable to problems of addiction (See Hilliard and Cole, 1993). Disempowered communities require a balance between personal, political, religious, and professional frameworks of recovery, and the nature of that balance (which component is emphasized) may need to evolve over time. As groups/communities achieve revitalization, more personal and less politicized frameworks of recovery become prominent.

2.8 Concepts that "Work" *To be successful, the core concepts of recovery advocacy movements must "work" at personal, professional, community and cultural levels.* They must provide ideas, language, and ritualized experiences that are personally redemptive for those who devote their energies as the soldiers of this movement and to those who are still seeking a way out of their entrapment in alcohol and other drug-related problems. Recovery advocacy movements need to also work at a professional level by changing the way that professional caretakers perceive and respond to addiction and addicts, and by changing the value that society attaches to those who devote their lives to helping resolve such problems. Recovery advocacy movements need to also work at community and cultural levels to define who has ownership of alcohol and other drug problems and how such problems are to be managed. The historical intractability of alcohol and other drug problems suggest that cultural ownership of these problems is inherently unstable (Room, 1978).

2.9 New Kinetic Ideas To alter public opinion, *successful movements condense complex ideas and needs into easily digestible slogans. Once these have achieved broad social acceptance, they may need to be de-constructed for the movement to move toward full maturity.* Where such maxims become concretized and reified, the movement sets itself up for a future ideological backlash. A most recent example of this can be seen in how the over-simplification and reification of the disease concept of alcoholism set the stage for a subsequent scientific backlash against this idea. Dwight Anderson and Marty Mann, who defined the core ideas of the modern alcoholism movement in the early 1940s, characterized such ideas as "kinetic" for their potential ability to move people and incite change within major cultural institutions. Their kinetic ideas focused on the nature of alcoholism (as a treatable disease), the nature of the alcoholic (able to be helped and worthy of being helped), and the physical and social consequences of alcoholism (the status of alcoholism as a major public health problem) (Anderson, 1942; Mann, 1944). Developmentally, *it is time to shift the focus of this enduring advocacy movement from the nature of addiction to the reality of recovery.* The "kinetic" ideas for this new movement need to shift from a focus on pathology to a focus on the potential for recovery at the levels of the person, the family, the neighborhood and the community. This new focus will not be on the problems that alcohol and other drug use inflicts on a community but on the problems recovery removes from the community and what recovery positively contributes to the life of the community. The recovery movement will need to formulate and introduce a new set of kinetic ideas to guide its education and advocacy work. I believe that the following ideas will become central to this new movement.

1. *Addiction recovery is a reality*.

2. *There are many paths to recovery.*

3. *Recovery flourishes in supportive communities*.

4. *Recovery is a voluntary process*.

5. *Recovering and recovered people are part of the solution; recovery gives back what addiction has taken.*

2.9.1. Addiction recovery is a reality for individuals, families, neighborhoods, and communities. The recovery movement will need to underscore this reality with faces, with stories, with numbers. It is time we introduced the community and the culture to hundreds of thousands of people in long-term recovery from addiction.

2.9.2 There are many paths to recovery that are reflected in different structures and styles of recovery. In 1944, AA-cofounder Bill Wilson, responding to queries about why a story of "solo recovery" had appeared in the *A.A. Grapevine*, stated a simple but widely ignored truth: "the roads to recovery are many" (Wilson, 1944). These paths mirror the considerable diversity in the etiology, onset, course and outcome of alcohol and other drug problems. The recovery movement needs to celebrate the growing variety of structures and styles through which individuals are permanently resolving these problems.

The expanding varieties of recovery experiences are reflected in the growing diversity of AA/NA and other Twelve Step group experience (Kurtz, 1999), the proliferation of mutual aid adjuncts and alternatives to AA/NA, a proliferation of religious and culture frameworks of recovery, as well as many emerging styles of "solo recovery."[2] The images that project from this movement into the wider society need to mirror the growing diversity of the culture of recovery. AA, NA, CA, WFS, SOS, RR and MM are a patchwork of organizations who differ markedly in their philosophies about the source and solution to AOD problems, but who share an enduring optimism about the potential for permanent resolution of such problems. Rather than fight with each other over THE right way to recover, it is time to acknowledge what anyone with any observational skills and common sense has known for a long time: *people with myriad patterns and circumstances surrounding their problematic relationships with alcohol and*

[2]"Solo recovery" (also described by this author as an "acultural style" of recovery, White, 1996) involves pursuing recovery from addiction without on-going relationships with formal addiction treatment, mutual aid structures, or significant support from other people in recovery.

other drugs are finding diverse ways to initiate and sustain their resolution of these problems. It is time we celebrated the growing pluralism of the culture of recovery.

2.9.3 *Recovery flourishes in supportive communities* (that create space for recovery to grow). Major agendas for the recovery movement includes helping create space within communities where recovery can blossom and to then nourishing and celebrating these local recovery communities.

> *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 here that, in discovering one's self in the stories of others, people discover both 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.[3] 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* (White, 2000d)

Recovery advocacy is not an advocacy for special treatment but an advocacy for justice: equitable access to health and social services and freedom from discrimination. Recovery flourishes in communities that value justice.

2.9.4 *Recovery is a voluntary process*. Those addicted to alcohol and other drugs have all manners of coercive influences that challenge their continued AOD use. Natural coercion of the addict (the push forces that propel the addict toward a recovery process) come from the natural and accumulating consequences of addiction applied by those whose lives are impacted by the addict's behavior. *The world will deliver sufficient pain and threat to the door of the addict; the role of the recovery community is to deliver to the addict a message of experienced-based hope.* It is not the

[3]Kurtz, E. (1997a). Spirituality Workshop. Presented January 10-12, Little Rock, Arkansas; Kurtz, E. (1997b). Story, Memory and Identity. Presented at University of Chicago SSA Professional Development Program, October 31.

role of the recovery community to be the agent of such coercion. While treatment and exposure to mutual aid groups can be coerced, enduring recovery comes finally only through choice. Recovery involves the resurrection of the will and (for most people) a mobilization of resources beyond the self. The role of the recovery community is to create a welcoming sanctuary (a pull force) where the coerced can find, not an agent of punishment, but an agent of hope. Coerced recovery is an oxymoron; one cannot be forced to be free.

2.9.5 ***Recovering and recovered people are part of the solution*** (to alcohol and other drug problems). *Recovery opens opportunities to give back what addiction has taken* (from individuals, families, neighborhoods, and communities). There is a profound sense of justice in the universe. If you disturb that balance, you take on a debt of obligation to restore it. Recovery takes a community's historical deficits and turns them into assets by challenging those in recovery to accept the mantles of restitution and service.

Recovering addicts repay their debt to the community through acts of restitution, by returning to productive roles in their families and workplaces, and by putting resources into the community rather than taking resources out of the community. The recovery movement offers the challenge of redemptive service: "You have been part of the problem; now be part of the solution!"

The service mantle offered by the recovery community can be actualized in many forms, but one potentially controversial form is that of breaking public silence and taking the act of advocacy public. The recovery movement offers a challenging invitation: "If you have found recovery, consider giving the community your story as an instrument of hope and healing. If you have been blessed by resources that helped you find and sustain recovery, then join the fight to expand those resources for those who are still suffering." The key in this is personal choice: the right of each recovering person to determine if, when, and at what level of detail their recovery story is shared. Recovering people bring quite different individual circumstances to this question and affiliation with divergent support structures. The recovery movement will need to be exceptionally tolerant of individual choice regarding public disclosure of recovery decisions as it seeks its overall goal of creating hope for recovery and creating visible pathways of entry into recovery. Public self-disclosure of one's story is just one of a broad spectrum of gifts recovering people can offer to this movement.

2.10 The Cost of Recovery While there is legitimate concern about the skyrocketing costs of acute episodes of addiction treatment, "the vast majority of people

in recovery manage the chronic and recurring nature of their disease at no cost to the taxpayer or the health care system" (Gertig, 1997). The successful management of long-term addiction recovery exacts fewer costs than the management of almost any other chronic disorder. The most important elements of sustained recovery--the commitment of self and the support from family, friends, and other recovering people--come without a price tag, and it is the nurturance and mobilization of those elements that are the primary mission of the new recovery movement.

2.11 Redefining Recovery The varieties of recovery experience call for this new movement to contemplate the very definition of recovery and sobriety. "Recovery" can entail a complete elimination of AOD use and AOD problems AND it can also entail a significant reduction in such use and problems. Recovery from addiction, like recovery from other serious medical disorders, can involve patterns of full or partial remission. AA recognized this continuum of outcomes from its inception; it was one of the first alcoholic mutual aid societies that did not threaten to expel members who relapsed. AA asked not for perfection but for progress; the requirement for membership was defined not as the achievement of permanent sobriety but a "desire to stop drinking." Recovery is the process of bringing alcohol and drug problems into a state of stable remission. From individual to individual, that process may require many diverse strategies and steps. As the recovery movement seeks to define the boundaries of recovery, it will need to address many potentially contentious issues: Can and should harm reduction activities play a contributing role (e.g., information. engagement) in this long-term process of recovery? Should individuals who have been long stabilized on methadone be welcomed with full status into this recovery community? The long-term fate of this movement may hinge on its ability to tolerate differences and tolerate boundary ambiguity while forsaking calls to create a closed club whose exclusiveness would leave many suffering people refused entry at its doorway. Somewhere in this movement's maturation, a message of unification needs to be extended that psychologically and socially links the growing number of recovery groups and solo flyers into a community of shared experience that can transcend differences and allow it to speak powerfully on one issue: the very real hope for permanent recovery from addiction. It is crucial that a way be found to transcend the internalized shame that turns members of stigmatized groups upon each other in frenzies of mutual scapegoating. The most serious battles fought by this movement are best waged, not with each other, but with more formidable forces in the culture that seek to objectify, demonize and sequester all those with AOD problems.

2.12 Models of Change The current generation of recovery advocacy groups is among the first to utilize theoretical models of social change to guide their development of strategies and tactics, e.g., Ghandi, King, Alinsky, Freire. It is this generation of recovery advocacy groups that will, through their unique histories, reveal whether such models enhance outcomes or whether it is better to have a model evolve out of a particular local, historical and cultural context.

2.13 Core Activities. Seven activities constitute the heart of the recovery movement:

1) *Recovery Needs Assessment* (identifying recovery obstacles, evaluating existing treatment/recovery support structures, identifying needed recovery support services).

2) *Recovery Education* (lay and professional).

3) *Resource Development* (philanthropy, fund-raising, grant-writing assistance, volunteer recruitment, participation in service planning/evaluation structures).

4) *Recovery Resource Mobilization* (community organizing; operating/supporting centralized information and referral services serving as client advocates).

5) *Policy Advocacy* (federal, state, and local political advocacy regarding legislation, regulation, programming, funding).

6) *Recovery Celebration* (enhancing identity and cohesion of recovery community, making recovery visible in the community, putting human faces on recovery via major media outlets).

7) *Research* (supporting a recovery research agenda: see later discussion).

2.14 Toward Realistic Images The modern alcoholism movement took the humor out of “drunk jokes,” conveyed the terrible toll that alcoholism takes on individuals, families and communities, and altered the image of the alcoholic from that of a skid row derelict, to one’s next door neighbor, or one’s own family member. Perhaps the apex of this destigmatization campaign came the moment that First Lady Betty Ford told the nation about her treatment for alcoholism and her continuing recovery. Her disclosure reflected a Camelot period in which people from all walks of life declared their recovery from alcoholism. But many of those images have disappeared as America has begun to restigmatize the alcoholic and the addict. Watching the instruments of popular media, one could rightly ask whether anyone goes to “rehab” other than celebrities caught in their latest indiscretion. Watching millionaire, celebrity athletes announcing their re-entry into a private treatment center following their latest failed drug

test, one could rightly ask whether anyone every really recovers from addiction to alcohol or other drugs. The faces of barely sober addicts on television screens need to be replaced by the faces of people from all backgrounds who have survived addiction to live full lives. With no other disorder do we ask people in the earliest days of recovery to speak as if permanent recovery had already been achieved. It is not that the floundering, newly sober celebrity is not welcome in the culture of recovery; it is that portraying this person as the culture of recovery is a gross misrepresentation of reality. It is also a fact that thrusting individuals in the earliest stages of recovery into the limelight is to invite disaster for them as well as the movements they represent.

The focus needs to shift from the addiction, the addicted, and the barely sober, to those in sustained recovery. Attitudes toward cancer and people who experienced cancer weren't changed by portraying dramatic images of cancer's potential devastation—a fact too painfully known by most citizens. Nor were such attitudes changed by having people survive their acute treatment experiences. Attitudes changed when, as a culture, we reached a critical mass of visible people who had recovered from cancer and went on to live full lives.

Superficial lip service that alcoholism is a disease will not change how the culture views the alcoholic if the reality of recovery is not brought into the direct experience of the citizenry. The 19th century ribbon reform club movements (noted for the practice of recovering people wearing a ribbon on their clothing) were not only for mutual identification and support but a means of conveying hope to a larger community that enduring recovery was not only possible but a living reality.

2.15 Accurate, Hopeful Language *One of the challenges of the recovery movement will be how to reduce the stigma attached to a condition and those who suffer from it with a cultural language that is heavily laden with the stigma.* The movement will need to enter into serious debate about how to refer to those suffering from alcohol and other drug problems and how to refer to those who no longer experience such problems. The vogue in recent years, that many have attacked as superficial political correctness, is to replace labeling individuals as conditions or things ("the disabled," "chronics") with a less objectifying and stigmatizing "first person" language ("persons with disabilities," "persons suffering from severe and persistent mental illness").

In the addiction recovery arena, two sets of language may be required--one for internal and one for external communications. Because mutual identification and linguistic candor are so much a part of the American culture of recovery, self-identification using the terms "alcoholic" or "addict" possess utility as tools of personal change that will continue well into the future. I would, however, recommend that, at the

level of public discourse, the terms “alcoholic” and “addict” be replaced with first person language (“person experiencing alcohol (drug)-related problems”) that is less objectifying and socially stigmatizing. This would also provide a way to escape the cultural confusion over exactly who is and is not an alcoholic, and by doing so shift the focus from the technical application of this label to a focus on the precise consequences of alcohol and other drug use on users and those closest to them. If we continue to use the language of “addicts” and “alcoholics” (as I am prone to do after more than 30 years in the addiction treatment/recovery worlds), we might at least consider referring to “alcoholics in recovery” and “alcoholics not yet in recovery”--a way to signal the reality of the former and optimism for the latter.

There are also potential benefits of using multiple terms at the level of public and professional discourse that could convey the developmental stages of addiction recovery and the continuum of remission patterns. The terms “seeking recovery,” “in recovery” and “recovering” could continue to be used to depict individuals who are making concerted efforts to remove destructive patterns of alcohol and other drug use from their lives, while the term “recovered” could be used to depict those who have achieved an extended (perhaps 5 years)[4] period of symptom remission.

2.16 Transforming Existing Social Institutions *To be successful, advocacy movements must engage primary cultural institutions.* The change induced by such movements must extend itself into and be anchored within the heart of society rather than being a superficial and potentially transient appendage to it. Like the alcoholism movement that preceded it, this new recovery movement must generate many smaller movements to carry its message of hope for recovery to the very heart of the culture and into the realms of media, government, law, medicine, business, education, religion, and entertainment. The concept of “recovery community” must be extended to the creation of micro-communities within neighborhoods, schools, churches, workplaces, and the courts.

2.17 Movement Scope Eventually, the new recovery movement will need to organize at local, state/regional, and national levels. We must build this movement within local recovering communities while building connecting tissue and forging an inclusive identity across these communities. Given the enormous diversity of local groups, both in terms of their membership composition and their primary foci, the national movement must be able to embrace groups with widely varying philosophies and agendas. The question of whether it is better to energize an existing national

[4]The traditional time period to medically designate recovery from a potentially chronic disease.

organization with a compatible mission or create a new organization depends to a great extent on whether the existing organization can meet this challenge of inclusiveness.

3.0 Movement Pitfalls

Virtually every aspect of how an AOD-related advocacy movement is launched and sustained contains the seeds of that movement's success or demise. *The major pitfalls of AOD-related mutual aid and advocacy groups have included mission diversion, ill-conceived or ill-defined core ideas, ideological extremism, commercialization, professionalization, charismatic leadership, organizational isolation, external co-optation, premature and superficial success, and unmanageable growth or attrition.* What follows are some brief reflections on some of these pitfalls.

3.1 Professionalization and Commercialization *The twin threats of professionalization (preoccupation with power/status) and commercialization (preoccupation with money/property) have often proved fatal to advocacy movements.* The professionalization of helping systems can inadvertently undermine indigenous supports for recovery, shift the focus of a movement from experienced knowledge to second-hand knowledge, and shift the service relationship from one that is enduring and reciprocal to one that is time-limited, hierarchical, and commercialized. In this transition toward professionalization, the functions of the movement are essentially commodified and privatized, risking a shift in focus from service to others to financial gain and achievement of professional status. John Gough and John Hawkins, the two most famous recovering Americans of the 19th century, abandoned their roles as indigenous leaders of alcoholic mutual aid societies to pursue careers as paid temperance lecturers. The best antidote against this pitfall is to make sure that the bulk of resources go to support service activities rather than property or personnel. The primary focus of the movement should remain on *voluntary action*. When moral entrepreneurs evolve into business entrepreneurs, the social movement that they started evolves into an industry that may lose touch with its historical mission. One wonders about the emotions of Harold Hughes, who after leading the battle to create federal funding for community-based alcoholism treatment, later lamented the emergence and explosive growth of an "alcohol and drug abuse industrial complex."

In the transition between social movement and industry, some movements become social/commercial phenomenon marked by celebrity speakers, books, journals, audiotapes, and innumerable movement icons. There is nothing inherently wrong with such trappings; they characterize the most successful of movements. But there is a danger that the soul of a movement can be corrupted by the crass commercialism that often marks the shift from movement to pop cultural phenomenon. The proliferation of

such items in the 1980s led some to coin the term “recovery porn” to classify this genre of items whose intent was more one of making money than supporting recovery.

3.2 Money and Movements *It is better to have an unfunded or under-funded movement than to have a well-funded movement whose mission is corrupted by the source or level of that funding. It is better to have the inception of a movement postponed than to have that birth prematurely induced by money that deforms its subsequent development.* Strategies of financial support that work in the short run can sometimes undermine a movement in the long run. Movements can die from a lack of resources, but they can also die from the turmoil, restrictions, and diversions that resources can bring. To the new generation of grass roots advocacy organizations I would say:

> Carefully heed the adage ‘he who pays the piper picks the tune’; find your own voice and sing only your own song. Be aware of seeking funding from any source that changes, no matter how subtly, your thinking, your vocabulary, your mission, or your methods. Find a way to use money temperately to achieve your mission; money has no value and becomes destructive when it takes your “eyes off the prize.” If you evolve into funded treatment agencies, you will have failed by professional absorption.

What happened to the advocacy organizations of the 1960s and 1970s was that they evolved into funded treatment and prevention agencies. They ceased being volunteer-based advocacy organizations and became professionally-directed service organizations. Rather than serving as a support to and as the conscience of the emerging treatment system, they became part of that system. In fulfilling an important unmet need, in stepping in to fill that void, they abandoned their original mission. Their organizations survived but their advocacy missions did not, and it was that failure that left a void of need that set the stage for the current re-emergence of advocacy agencies in the addiction/recovery arenas. Some of the most successful social movements that were able to bring together diverse constituencies behind a single goal then fragmented at the very time the success of that movement was imminent. *Dividing the “spoils of success” is one of the most precarious times for any social movement.*

3.3 Lost Stewardship When movements get institutionalized, there is often a progressive erosion in stewardship practices. Resources devoted directly to the mission in early stages get absorbed into organizational infrastructure and personal and/or professional enhancement in later stages. *The principle of stewardship demands that we monitor the resources that flow into and out of recovery movement organizations to assure that resources that once passed through the organization into the community, do not begin to remain in the organization.* The best test of whether we have remained true

to our founding mission is how we are expending our resources. Put simply, if you want to know the philosophy of a particular organization, don't read its vision or values statements, read its budget.

3.4 Self-destruction by Implosion or Absorption *The successes and potential vulnerabilities of mutual aid societies, treatment institutions, and social advocacy organizations often flow out of how they relate to the wider community.* The gravest dangers emerge from two excesses. The first is sustained isolation from the community, a stance that is often a precursor to cult-like extremism. Such isolation often results in stagnation and implosion, as can be seen in the histories of early (the New York State Inebriate Asylum) and modern (Synanon) treatment institutions. The opposite danger lies in such over-involvement in the community that the organization is vulnerable for colonization by more powerful forces. This risk of death by dilution, diffusion and co-optation can be seen in the histories of such groups as the Washingtonians and the Keeley Leagues.

Leaders of recovery advocacy movements need to cultivate the ability to anticipate and read changing cultural winds. *Effective recovery movement leaders carefully monitor changes in their operating environment and regularly ask, "What does this unfolding event and the culture's response to it reveal about the status of our mission and our methods?"*

3.5 Premature Victory (The Dangers of "Super Success") *There is danger that movements focusing on reducing stigma prematurely claim victory in the face of a positive media attention or sudden (but often superficial) shifts in public opinion. The fastest way to kill anything in America is to turn it into a superficial fad that dies from distortion and over-exposure.* The Washingtonians died, in part, from over-exposure, and one of the greatest threats to AA came in the 1970s and 1980s at the very time that the rehab/recovery fad was generating explosive growth in AA. The threat was that historical AA would be drowned in a sea of treatment psychobabble and commercialized recovery paraphernalia. *The most insidious death of the recovery movement could occur if the essence of that movement died while the illusion of its continued existence remained. This would be an invisible death--a death by value dilution and corruption*.

Cosmetic change can pacify a movement and lead to claims of premature victory. Such superficial change (tokenism) often masks the absence of fundamental change.

Social change is like personal change in that it involves the twin challenges of initiating change and then sustaining that change over time. Social change, like personal recovery, requires a maintenance program in order to avoid regression and

relapse. It has been interesting to watch recovering people whose own transformation spans years of false starts and regressions get involved in advocacy and become impatient and angry at the slow pace of change in their communities. *Conversion experiences are rarer for communities than they are for individuals; social change often involves the same slow stages of change that so often mark the process of personal recovery.*

3.6 Mission Diffusion *One of the most significant challenges of any advocacy movement is to maintain fidelity to its founding mission.* What looks like a natural extension of mission can turn out to be a fundamental diversion from mission. A movement initiated with a narrow agenda may absorb other agendas as it gains momentum; this agenda acquisition process can alter the character and future of the original movement. This is evident in the transformation of occupational alcoholism services into employee assistance services, then into behavioral risk management programs (the drug free workplace movement), and, more recently, into managed behavioral health and work life programs. These shifts created, not by intent but by consequence, a lost focus on recovery resources for addicted people. To avoid what will be innumerable temptations, *the recovery movement will have to find a way to clearly define and maintain its singleness of purposes and to avoid political and financial entanglements that could divert it from that purpose.* If these newly emerging advocacy organizations themselves become overly preoccupied with maintaining their own infrastructures or evolve into service agencies, they will have failed, as measured by fidelity to their founding mission.

3.7 Methods and Mission Social movements often go awry when their emerging methods conflict with their mission and core values. *The means used by movements to achieve their mission must be congruent with that mission.* Recovery movements must be, above all, grounded in recovery values: honesty, simplicity, humility, gratitude, and service.

3.8 Stigma Close to Home Organizations providing recovery support services will have to confront stigma from a most unexpected source--those who fund addiction-related services. Representatives of funding organizations can exhibit such stigma via paternalistic judgements regarding what recovery-based organizations are capable of achieving. As the recovering community and its partners come together, the first task will be to explore how we act out the very stigma we are trying to remove in the larger society.

3.9 Scapegoating: Inclusion/Exclusion Movements organized by and for individuals from socially stigmatized groups are prone to create exclusionary class structures regarding movement participation. This phenomena represents a type of "Stockholm Syndrome" through which traumatized victims mimic the behaviors of those who have controlled their fate. Exclusion, scapegoating and extrusion of particular groups of individuals, and intra-movement schisms and warfare are all ways that oppressed groups avoid confronting more powerful forces in the larger social/cultural environment. The "modern alcoholism movement" of the 1940s-1960s was to a great extent a movement whose aim was to make alcoholism a respectable disease for those who had already achieved recovery, particularly the elite who, without the stain of alcoholism, could resume their positions of cultural entitlement. Pecking orders of status based on drug of choice, support structure affiliation, style of recovery, treatment modality, and degree of recovery (defined quantitatively and qualitatively) have all served to divide the recovery community, as have issues of gender, race, and social class. *Before the recovery movement can confront stigma in the larger society, it must confront how that same stigma gets acted out as a destructive force inside the movement*. *Developing an inclusive recovery movement requires skills in cross-cultural communication, conflict resolution processes, and safe sanctuaries where healing and cross-cultural communication and relationship-building can occur*.

3.10 Those Left Behind *Movements that are created to advocate on behalf of the most disempowered often leave these very individuals behind as the focus of the movement seeks wider social acceptance*. To alter the image of the alcoholic/addict, there is a danger that those who come closest to the demonized caricature will be left behind in the wake of the movement's success. In emphasizing that the skid row alcoholic was only 5% of alcoholics, the skid row alcoholic (and the poor alcoholic, in general) was excluded from most of the treatment and recovery support services that marked the expansion of such services in the late 1970s and 1980s. The recovery movement will also have to guard against the process of inversion: shifting its primary focus from the needs of the still suffering (those not yet in recovery) to the needs of the stable (those who are in recovery).

3.11 Movement Coalitions Successful social change movements bring together broad, multi-agenda coalitions who may support a single goal but then fragment into competing camps as success nears or is achieved. The future fate of some movements are set in the earliest formation stage of the movement when coalitions are created by parties whose long-term interests are incompatible, e.g., MADD and SADD accepting financial support from the alcohol industry. What many groups did not realize was that what presented itself as an opportunity to push the movement forward turned out to a source of mission corruption and a source of damage to the movement's image and

credibility. *Compatibility of primary interests is an essential principle in creating effective social movement coalitions.* Successful movements bring together multiple stakeholders with diverse agendas while guarding against attacks from persons and institutions whose interests are threatened by the new movement. *As local recovery advocacy movements emerge, defining friends and enemies of the movement is not always easy. It is best not to enter into alliances until one's own organizational identity (mission, core values) has solidified.*

3.12 Developmental Stages *There are predictable developmental stages in the life of AOD-related advocacy organizations.* The first challenges are for an organization or larger movement to get launched and then establish its niche within the alcohol and drug problems arena. At this point, the organization must compete with other AOD problem stakeholders in the marketplace of ideas and compete for resources and the public's attention. Fledgling movements must emulate the "little engine that could" by acting as if they are a movement until they become a movement.

Crucial developmental tasks during this period include the emergence of organizational leaders; the formulation of a viable organizational structure and decision-making processes; the codification of the mission, vision and core values; the emergence of core methods and activities; the creation of a resource development strategies; and the structuring or relationships with other organizations within and outside the AOD problem arena. The future success or failure of an organization is often shaped by how well these early tasks are managed.

To achieve maturity requires both time and the completion of other critical developmental tasks: resolving problems of charismatic leadership, addressing leadership development and succession, working out on-going questions regarding strategies and tactics, finding sufficient resources to sustain the organization and its core activities, and balancing the emotional needs of members with the demands for increased organizational efficiency. The most significant danger at this stage is the tendency of the movement to move toward professionalization and bureacratization. The risk is that the focus and passion that spawned the organization get lost in the shift in focus from why things are done and their effects to a preoccupation with how things are done.

Organizations and movements, like individuals, can die from old age. To sustain a movement requires a structure of leadership development, membership recruitment, and continued resource development, but it also requires that the movement's core ideas and strategies get re-interpreted and sometimes redefined in light of changing political, economic, and social contexts. *The ebb and flow of energy within social*

movements is normal and can be actively managed with periodic renewal processes/rituals.

3.13 Movement Stages and Movement Roles *Three overlapping roles can be found in the history of destigmatization movements: moral entrepreneurs, business entrepreneurs, and technocrats.* A movement's fate is dictated in part by which of these roles dominate at different stages of the movement. There are similarly different backgrounds and skills needed at different stages of social movements. The job of the moral entrepreneurs is to use their personal charisma to call the community's attention to unmet needs and to mobilize interested parties into a sustained movement to address these needs. The job of business entrepreneurs is to create viable, sustainable organizations and to codify their products and services. The job of the technocrats is to sustain this organization and refine its products and services over time. Some individuals will likely end up performing all three roles over the course of their involvement in the recovery movement. Technocrats fail at leading movements just as moral entrepreneurs often fail at sustaining organizations. The key is to match the right leadership role with each particular developmental stage of a social movement and to weather the personal and organizational strain during the transition from one stage to the next.

3.14 Member Attrition *Nearly all movements experience critical periods of member attrition through which oral history, core values, and key areas of technical knowledge are diluted or bled out of the organization.* Such crises suggest the need for ongoing membership recruitment that crosses generational lines and the need for archivist whose contribution to the movement is to prevent such valuable knowledge from being lost. Movement records provide an opportunity to honor the history of the movement as well as study and reinterpret key documents for their contemporary import.

3.15 Counter-movements *Movements that acquire visibility and influence often generate their own counter-movement*. Once movements become visible on the cultural horizon, they become a target of those institutions whose interests they threaten. The degree of success of any movement--the civil rights movement, the environmental movement, the gun control movement--cannot be fully ascertained until that movement has weathered the counter-movement that it generates. Counter-movements can gain energy and credibility by capitalizing on flawed elements of philosophy or strategy that occur early in a movement's history. For example, the narrowly defined disease concept of alcoholism that produced a workable slogan for de-stigmatization campaign from the 1940s to the 1970s eventually triggered a scientific and clinical backlash against this very concept in the 1980s and 1990s. Tomorrow's attacks upon a movement from

without are often the shadow of today's misuse of ideas, people and resources within the movement. It would have been hard during the very height of the destigmatization of alcoholism in the U.S. in the 1970s to envision the ideological and economic backlash against treatment and recovery that would begin in the following decade. *Counter-movements germinate within the soil of a movement's excesses.*

3.16 Defining Moments There are defining moments in all social movements. It is the decisions made in the heat of these moments that determine the fate and character of the movement. Some of these moments are recognizable as they unfold; others are recognizable only in retrospect and can consume hours of "What if?" discussions. *Recovery and advocacy movements succeed or fail by either capitalizing on or failing to recognize such narrow windows of threat or opportunity.*

4.0 The Recovery Research Agenda

4.1 Technological Advances *There are critical stages in most successful social movements that require breakthroughs in technology for the movement to proceed.* The goal of expanding reimbursement for alcoholism treatment could not have been successful without: 1) acceptable diagnostic criteria, 2) replicable treatment models, 3) alcoholism treatment program accreditation procedures, and 4) alcoholism counselor credentialing procedures. The emerging recovery movement will reach a point where it cannot proceed without a foundation of scientific research on recovery itself. (An effective use of federal, state, and private philanthropic dollars would be to support the development of this critical technology.)

4.2 The Recovery Research Agenda The question of "how do we get persons suffering from alcohol and other drug problems into treatment?" needs to be reframed to the question of "how we get them into recovery?" The answers to these two questions are not necessarily the same. *The future of the recovery movement does not hinge solely on recent or future scientific data on the etiology of AOD problems/addictions. It hinges on the emergence of a science of recovery extracted from the lives of those who have achieved such recovery*. Scientific breakthroughs on the etiology of addiction are relevant only to the extent that they provide clues to the prevention of addiction and clues to successful recovery pathways and strategies.

We know a great deal about addiction and that body of knowledge grows daily, but we know very little about recovery. We have elaborate systems to measure the incidence and prevalence of AOD use, and AOD problems, but virtually no comparable systems that can tell us the number or characteristics of those who have found enduring solutions to these problems. We study the status of people a few months or a few years

following a treatment episode, while we know virtually nothing about people whose recovery is measured not in weeks or months but in decades.

Treatment studies are not recovery studies; studying recovery by studying treatment is like studying human life by studying only birth. Our studies of addiction have produced only humble results. *Perhaps it is time we expanded our focus beyond the study of the addiction problem and the effects of various treatments to include studies of the broader recovery solutions.* The shift being called for is one that moves the focus of our attention from one of the study of risk/pathology to one of recovery/resilience/possibility. A recovery research agenda would include attempts to answer such basic questions as:

- How many recovering and recovered people are there in the U.S.?
- How do the characteristics of those who are in recovery differ from the characteristics of those people with AOD problems who are not in recovery?
- What are the processes, strategies, support structures, environmental contexts, and precipitating events that characterize such recovery?
- How do recovery pathways and styles vary by age of onset of use/recovery, duration of use/recovery, gender, ethnicity, education, class, living environment, sexual orientation, religious affiliation, disability and primary drug of choice?
- What resources play the most critical roles in successful recovery from AOD problems?
- What are the variety of patterns represented in the recovery process, e.g., patterns of full remission, types and styles of partial remission?
- Are the rituals and structures that support long term recovery different than those that support early recovery?
- How do the mechanisms that support solo recovery differ from recovery that is mutually supported?
- How do different recovery structures and styles differ qualitatively, via Wilson's concept of "emotional sobriety?"
- What events or circumstances contribute to relapse by those who have achieved long (more than 5 years) of symptom remission?
- What activities (across recovery styles/structures) are most predictive of symptom remission?
- Do "harm reduction" interventions constitute a pathway of entry (an early developmental stage) of recovery or do they postpone or divert recovery decisions?

There is much that could be gained by pursuing a recovery research agenda. We have multiple taxonomies of alcoholism/addiction but virtually no taxonomy that depicts the variety of subgroups who have successfully achieved long term recovery. Who are these people and what subgroups make up this growing "recovery community?" Do different subgroups use different support structures and mechanism of self-governance to sustain their sobriety?

It is time the recovery community created an activist-based, solution-focused research agenda: an agenda that seeks not merely understanding but one that seeks knowledge that can make a difference in the lives of individuals, families and communities. Support for recovery research could be made contingent upon whether the findings of a proposed study will help initiate, sustain, or enhance the quality of recovery.

5.0 Leadership

5.1 Source of Movement Leadership *The leadership of the recovery movement must come from the recovery community and the movement's agenda must be those of recovering people and their families.* Great care must be taken in avoiding the problem of double agentry--individuals speaking openly as recovering people while their voices actually represent hidden professional or institutional interests. The movement must guard against those who will seek to colonize this movement to further their own personal, professional, and proprietary interests. Federal/state alcohol and drug authorities, treatment institutions, and treatment professionals may be supporters, members, and partners within this movement, but the leadership must come from within the indigenous recovery community. Where few indigenous resources exist, local treatment agencies/professionals can play a role in nurturing the development of such resources, but it is the recovery community itself that must eventually assume the central role in recovery advocacy and in the design, delivery and evaluation of key recovery support services.

5.2 The Problem of Centralized, Charismatic Leadership There is a unique paradox related to the issues of leadership of advocacy movements. *Advocacy movements need strong leadership and yet can be wounded by that very style of leadership.* The centralization of power and decision making in a single leader (and his/her inner circle) can, over time, magnify even minor character flaws into major sources of personal/organizational vulnerability. The best antidote to such vulnerability is a style of leadership that is democratic (facilitative rather than directive) and regularly rotated, or tandem leadership in which two or more leaders serve jointly, each tempering the potential excesses of the others. (An historical example of tandem

leadership in the early stages of a movement can be found in the relationship between AA's co-founders.)

5.3 Personal Price of Leadership The recovery movement is greater than its leaders, and it is that higher value which compels these leaders to honorably represent the movement and to not wound the movement through personal excesses or indiscretions. *What advocacy movements demand of their most visible leaders is not perfection but continual vigilance and a reasonable congruence between the life lived and the implicit and explicit values of the movement.* The weight of this mantle of leadership can be a considerable one.

5.4 The Vulnerability of Leaders (The Curse of Icarus) *When a whole movement is linked to the reputation of a single man or woman, whose reputation is then publicly wounded, such wounding can prevent the full emergence of a movement or, once emerged, lead to the premature diminishment or death of that movement.* Men and women who have conquered all manner of addicts can become intoxicated with their leadership positions and the holiness of their new cause. It is not unusual for such individuals in the throes of such intoxication to fly to close to the sun and then plummet to their demise, sometimes taking their movement with them. As the recovery movement builds, those who successfully led smaller groups may be thrust into larger arenas in which even minor character defects can be magnified into potentially fatal flaws. This can be particularly true for individuals in early recovery for whom the spotlight constitutes a most dangerous place. This capacity for excess can be tempered by rotating leadership, by openly recognizing such risks, and by building support systems that can help keep our leaders grounded.

5.5 Media and Leadership The media that feeds on today's story of our leader's dramatic redemption will tomorrow circle like vultures at the first sign of a fall from grace. *Over-telling the redemption story can set one up for such a later fall from grace.*

5.6 Leadership Development and Succession *Mutual aid, advocacy and treatment organizations can die due to their failure to adequately address the issue of leadership development and leadership succession.* Continuing membership recruitment across generational lines and rotating leadership practices are the two most successful strategies to sustain social movements.

6.0 Pleasures and Pitfalls of Movement Participation

6.1 The Nobility of Service Many people wake up in the early or middle stages of recovery with a sudden realization that they are alive and free from the obsession and physical appetite of addiction. This realization is also accompanied by what might be called survival guilt. Such breakthroughs of awareness can raise penetrating question about why one was saved when so many others were not. It is within such introspection, that one can feel the stirrings of "calling"--a sense that one was saved for some special purpose that must now be pursued. *For more than two centuries, recovering people have pursued this calling within the arenas of advocacy and service.*

6.2 Movement Participation *Successful social movements recognize and respect the fact that members bring different capacities regarding the duration and intensity of movement participation*. Successful movements create within their evolving membership a blend of short-term, task-oriented involvement and long-term commitment, like a track team with runners specializing in different distances. The future of any advocacy group is threatened by a membership of all short-distance runners.

6.3 Message and Messenger For recovering people to take on the role of advocate is not an act of ego; it is an act of service and an act of restitution. To those who would claim to be too imperfect an instrument to serve in such a movement, I would argue that *the greatest social movements have often been sparked and sustained by the small acts of imperfect and often unknown individuals.* If a recovery movement waited for those with perfect credentials, that movement would not be born, and if it was, could not succeed with such credentials.

The message of recovery has always been able to transcend the imperfections of its messengers. In fact, it is that "spirituality of imperfection," as Ernest Kurtz has christened it, that makes the recovery movement unique. It was this very movement that pioneered the concept of the "wounded healer"--the idea that acceptance of imperfection was the foundation of recovery, and that what imperfect people could not achieve alone they could achieve together. In every community and in the country as a whole, there are growing vacuums of need calling to be filled not by perfect servants but by willing servants---servants whose human imperfections can be transcended by collective action and the import of the recovery movement's cause.

6.4 Movement Demands/Strains Participation in recovery advocacy is not without its personal risks. *The passion required to elicit and sustain a social movement (whether local or national) can elicit a wide range of excessive behaviors.* Personal

participation can be wearing within any movement that at a personal level deals with such life and death issues and that at a cultural level confronts so much stigma and prejudice and absorbs so much overt and latent conflict. There is a vulnerability for excess among all who pursue roles in this movement.

6.5 The Primacy of Personal Recovery While the creation and sustenance of addiction treatment programs and public education/advocacy campaigns may be fueled by the passion of recovering people, *pursuing avocations/vocations in addiction treatment or community education and advocacy does not constitute a viable strategy for personal recovery*. The history of addiction in America is strewn with the bodies of those who believed otherwise. When helping, educating, and advocating for others is used as or replaces a personal program of recovery, there is a considerable risk of relapse. People involved in these activities must find a way to sustain themselves (and their personal recovery).

There are four daily rituals that have long marked the essence of addiction recovery and that have also characterized the lives of those who have sustained themselves for years of service work within mutual aid societies, professionally-directed treatment, and advocacy organizations/movements. These core activities include: 1) centering rituals, 2) mirroring rituals, 3) acts of personal responsibility, and 4) unpaid acts of unrelated service.

6.5.1 Centering Rituals are times and activities allotted to keep oneself focused or to get oneself refocused. These are daily rituals, usually performed alone, that allow us to renew that center of ourselves out of which our advocacy and service work flows. These rituals vary from person to person but often include reflection, refreshment, and renewal, whether it be through reading literature that pulls us toward our aspirational values or through quiet thought or prayer.

6.5.2 Mirroring Rituals are rituals through which we interact with others who share our core values. These rituals provide opportunities for public re-commitment, fellowship, support and laughter.

6.5.3 Acts of Personal Responsibility are those rituals through which we act out the healing power of recovery upon our own selves and those closest to us. It is making sure that in caring for others, we don't neglect our own needs. This caretaking extends beyond one's own physical, emotional and spiritual needs and extends to our intimate circle. One of the best pieces of advice I was ever given is captured in the following words: "One must be careful in carrying light to the community that one's own home is not left in darkness."

6.5.4 Unpaid Acts of Unrelated Service Performing unpaid acts of service unrelated to our primary cause is a way to freshly re-experience the commitment that drew us to this work. It is a way to connect with like-minded people in other arenas and to re-affirm our core identity and our core values.

6.6 The Potential Enormity of an Individual Life Many things compete for our time and our energy, including many seemingly intractable problems facing our community, our country and our world. In the face of such challenges, how does one find or sustain the motivation that social movement advocacy demands? To make such a commitment requires getting beyond the belief in the meaninglessness of one's own potential minor contributions. *A theme that exists within the history of all great social movements is the potential enormity of a single life.* Consider what the actions of a single woman--Rosa Parks--meant to the American civil rights movement. Consider how the treatment of the mentally ill would be different today if there had been no Dorthea Dix. Consider whether a new recovery movement would even be possible today without the foundation laid by people like Marty Mann and Harold Hughes. It is only in retrospect that we understand how the actions of a single individual can spark or move forward a whole social movement. *The past history of recovery in America is a rich one; you can be an observer of that continuing history or accept the invitation to become an active part in it.*

7.0 Summary

There is a rich history of addiction recovery and advocacy dating back more than 250 years in America. The lessons buried within this history transcend the stories of the individual leaders, groups and communities. *These lessons of history can provide a source of technical guidance, a source of individual and organizational protection, a source of refreshment and renewal, and, most importantly, a source of unquenchable hope. We would be well advised to sit at history's feet and absorb the lessons of her stories. Perhaps if we listen carefully, she will not have to repeat herself.*

References

Austin, G. (1978). *Perspectives on the History of Psychoactive Substance Use.* Rockville, MD: National Institute on Drug Abuse/U.S. Government Printing Office.

Anderson, D. (1942). Alcohol and Public Opinion. *Quarterly Journal of Studies on Alcohol*, 3(3): 376-392.

Bloom, S. (1997) *Creating Sanctuary: Toward the Evolution of Sane Societies.* New York: Routledge.

Gertig, J. (1997) Some Thoughts on Organizing a Substance Abuse Treatment Grassroots Advocacy Constituency. Unpublished Manuscript.

Hilliard, D. & Cole, L. (1993) *This Side of Glory: The Autobiography of David Hilliard and the Story of the Black Panther Party*. Boston: Little, Brown and Company.

Johnson, B. (1973). *The Alcoholism Movement in America: A Study in Cultural Innovation*. Urbana, Illinois: University of Illinois, Ph.D. Dissertation.

Kurtz, E. (1999). The Collected Ernie Kurtz. Wheeling, West Virginia: The Bishop of Books.

Kurtz, E. & Ketchum, K. (1992). *The Spirituality of Imperfection: Modern Wisdom from Classic Stories*. New York: Bantam Books.

Lender, M & Martin, J. (1982). *Drinking in America.* NY: The Free Press.

Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol,* 5(2): 354.

Musto, D. (1973). *The American Disease: Origins of Narcotic Controls.* New Haven: Yale University Press.

Roizen, R. (1991). *The American Discovery of Alcoholism, 1933-1939.* Ph.D. Dissertation, Berkeley: University of California.

Room, R. (1978). *Governing Images of Alcohol and Drug Problems: The Structure, Sources and Sequels of Conceptualizations of Intractable Problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

Sinclair, A. (1962). *Era of Excess: A Social History of the Prohibition Movement.* NY: Harper & Row Publishers.

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

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000a). The Role of Recovering Physicians in 19th Century Addiction Medicine: An Organizational Case Study. *Journal of Addictive Diseases,* 19(2): 1-10.

White, W. (2000b, In Press) The History of Recovered People as Wounded Healers: I. From Native America to the Rise of the Modern Alcoholism Movement. *Alcoholism Treatment Quarterly*.

White, W. (2000c, In Press) The History of Recovered People as Wounded Healers: II. The Era of Professionalization and Specialization. *Alcoholism Treatment Quarterly.*

White, W. (2000d) Lost Vision: Addiction Counseling as Community Organization. Submitted for publication.

Williams, C. with Laird, R. (1992) *No Hiding Place: Empowerment and Recovery for our Troubled Communities*. San Francisco: Harper.

Wilson, W. (1944) *AA Grapevine*, 1(4): 4.



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. (2001) Recovery University: The Campus as a Recovering Community. *Student Assistance Journal*. 13(2):24-26. Posted at **www.williamwhitepapers.com**

The Campus as a Recovering Community: A Model Program for College-bound Students in Recovery

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Sarah is about to graduate from high school and like many of her peers is anxiously awaiting entrance into college. What makes Sarah's situation somewhat unique is that she is recovering from a substance abuse problem that nearly took her life. Both Sarah and her parents are apprehensive about how Sarah's newfound sobriety will fare as she leaves her current supports and faces old and new temptations in the college environment. The fears of Sarah and her parents are justified. One doesn't have to go far to hear stories about students whose fragile grasp of recovery unraveled in their transition from high school to college. Imagine the advantages if students such as Sarah could pursue their educational dreams in a recovery-supportive environment.

Having worked in the addiction treatment field for some three decades, I have often been asked for guidance from recovering students and their parents regarding this transition dilemma. However, it wasn't until recently that I discovered a most unique resource that I could share in response to such requests. Imagine a place where recovering students are eligible for scholarship assistance based on their recovery status. Imagine a place where recovering students support each other personally and educationally. Imagine a place where vibrant support groups and personal recovery assistance exist right on campus. Imagine a place where recovering students academically outperform their student peers. That place exists on the campus of Texas Tech University (TTU) in Lubbock, Texas. Here's what I discovered on a recent visit to the campus.

A Man and a Vision

The story of the Center for the Study of Addiction at TTU begins with the story of Dr. Carl Andersen, a professor at Texas Tech, who began his own recovery from alcoholism in 1982. Andersen entered recovery with advanced degrees in theology, special education and marriage and family, and a distinguished teaching career at TTU. When "Dr. A." (as he is affectionately know today by his students) returned to the University following his own treatment, he

wanted to direct his professional as well as personal energies toward the arena of addiction recovery. That interest culminated in the opening of the Center for the Study of Addiction (CSA) in September, 1986. His original vision was to provide an academic curriculum to prepare people to work as addiction counselors. During the very first semester, however, an incident occurred that exerted a profound influence on the future of the CSA.

One of the early CSA students confessed his addiction to alcohol and cocaine and asked Dr. Andersen to help arrange his admission to treatment. While in treatment, the student and his family contacted Dr. Andersen and expressed their concern about the lack of a drug free environment in which this student could continue his college education. That conversation was a turning point. Dr. Andersen explains:

> *The question of how this young man could continue his recovery in a supportive environment really got the wheels turning, and I realized we needed to create that kind of recovery environment right here on campus. What emerged was a vision of a community of recovering students who lived together, worked together, went to school together, and played together.*

Fourteen years later, the fruits of this vision can be seen as recovering students flow in and out of the CSA office to say hello or seek the advice of Andersen and his staff. It is quite a scene to behold: Andersen's powerful persona–tall, Texas-tanned, and ruggedly handsome with a honeyed drawl born for the pulpit–moving through the CSA reception area offering effusive praise to one student, a bit of tough love to another, and quiet counsel to still another. And equally important is the fact that these same types of interactions can be witnessed in the students' communications with each other and with the other CSA staff. This is not just a story about the achievement of one man, but a story of how one man's vision became a recovering community and how that community became a center of academic excellence.

The CSA Program

The goal of the CSA is to enhance educational opportunities and achievement for recovering students while supporting their continued recovery and emotional growth. Requirements to enter the CSA program include a high school degree or equivalency, one year of sobriety, and a commitment to fully participate in CSA's academic and support activities. The major elements of the Center's program include:

- Dr. Andersen and two other full time staff who coordinate the program, teach classes and provide counseling support to the students. (All staff are licensed chemical dependency counselors.)

- a scholarship program that to date has provided more than $300,000 in academic scholarships.
- a minority recruitment program that allocates nearly half of current scholarships to minority students.
- the Substance Abuse Studies Curriculum that academically prepares those students who want to pursue careers in addiction counseling or who want an academic minor in addiction studies.
- on-campus recovery support groups that meet in the "Serenity Center" several times per week with a combined attendance of more than 400 students.
- a Thursday night Celebration of Recovery gathering that regularly exceeds more than 100 students.
- a peer tutorial support program.
- an association of recovering students (Addiction and Substance Abuse Specialists) that sponsors professional development workshops and community service activities.

These elements are enveloped in a recovering community of more than 100 Texas Tech students. For Ashley Hix, a 21-year old Freshman in the CSA program, the CSA staff and her fellow students were like "instant family" when she arrived on campus. Andersen describes how a new student is integrated into this recovering community:

> *After visiting with me, I get them attached to two or three students who will take them to the Serenity Center, get them hooked up to get to support meetings, study groups, and social activities. They get phone numbers that become a safety net for them. From the time the student first walks in the door, they are connected to this larger community of support. They have people who they can rely on and people who will be looking out for them.*

Jim Harris, an enthusiastic first year student, provided an apt description of the CSA program when he stated that it offered people another chance who through their addictions had destroyed most of their early opportunities for success.

CSA's recovering community exudes a contagious hope and joy about the potential of recovery that permeates the larger TTU campus. Evidence of this effect is found in the fact that an average of one student per week from the larger campus enters recovery through his or her association with CSA students and activities.

Funding of the Center for the Study of Addiction has come from two major sources: early seed grants from the Texas Commission on Alcohol and Drug Abuse and a $1.3 million endowment. The contributions that created the endowment constitute not just a pool of money, but a deep reservoir of pain and joy. Andersen explains:

> *The dollars that endow our scholarships reflect tragedies and triumphs. We have scholarships named for people who lost their lives to addiction, and we have scholarships that reflect a deep sense of gratitude for the gift of recovery.*

CSA students are provided a $500 scholarship their first semester and then receive scholarships whose amounts are determined by their grade point averages: $2,000 for a 4.0 GPA, $1,500 for a 3.5 GPA, and down to $500 for a 2.5 GPA. Scholarships are re-calculated every semester, providing a direct link between level of academic performance and level of financial support. Andersen believes that these scholarship resources are crucial in supporting students who, having burned their financial bridges during their addictions, would not have access to higher education without such financial assistance.

The Results

Since 1986, students from all regions of the country (and from other countries) have come to Texas Tech University to be part of the Center for the Study of Addiction. To date, more than 4,000 students have taken courses through CSA, 733 have successfully completed the Substance Abuse Studies Curriculum, and more than 600 recovering students have graduated with bachelor's degrees. A study comparing the academic performance of the CSA students with those of the wider university found that the average cumulative G.P.A. for CSA students was 3.37 compared to the an average G.P.A. of 2.68 for all undergraduates at the University. CSA graduates have gone on to pursue graduate education in such areas as counseling, theology, medicine, law, and business administration.

One could surmise that the relapse rate would have to be quite low to produce such levels of academic achievement. In fact, the relapse rate of students in the CSA program has remained below five percent since its inception–a remarkable figure when one considers the high rate of relapse of young people following traditional substance abuse treatment. When relapse does occur, there is often a process of rapid re-engagement in recovery. One such student

shared what happened when she relapsed while in the CSA program.

> *When I relapsed, there were people here to help pull me out of that. Dr. Andersen and the staff and all the recovering students were so helpful and understanding and forgiving.*

With all these recovery support activities and all those good grades, it might appear that the climate of the CSA is a most serious and somber one, but this is not the case. Enthusiasm and laughter fill the air of the CSA program. The experience of being part of the CSA is illustrated by Stephanie Beck, a fourth year student. Stephanie had failed out of two high schools before getting into recovery and graduating from a third school. She was encouraged to go to Texas Tech specifically because of the CSA program. After noting how important the recovery supports and classroom help have been to her, she describes what to many might be the most surprising element of the CSA milieu.

> *A lot of people would think not drinking or getting high during your college years would be pretty boring, but we have a blast. Besides, we've done all of that, and that kind of so-called fun had long ago turned to pain for us. Today, we enjoy showing people how much fun we can have sober–the kind of fun you can feel good about and remember.*

When Dr. Andersen was asked to reflect on what he was most proud of as the founder of the CSA, he offered the following reflection:

> *There are so many young people in recovery who are just not going anywhere. They are in recovery, but their addiction took so much from them. I think I am most proud of how many of our students have made the transition not just from addiction to recovery but from addiction to responsible, productive citizenship. They have become more than recovering addicts; they have become real people who are now giving back to their families and communities.*

The Center for the Study of Addiction at Texas Tech University stands as one of the most innovative and effective approaches to recovery support that I have seen anywhere in the United States. It should be replicated in states throughout the country to provide recovering high school students and adults returning to college an environment in which education and recovery are not only compatible but inseparable.

Admission Information

Information on admissions and scholarships can be obtained by writing or calling: Dr. Carl Andersen, Center for the Study of Addiction, Texas Tech University, Box 41162, Lubbock, TX 79409-1162. (806)742-2891.



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. (2001). The new recovery advocacy movement: A call to service. Counselor, 2(6), 64-67. Posted at **www.williamwhitepapers.com**

The New Recovery Advocacy Movement: A Call to Service

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

A long series of American social movements have touched the lives of those with severe and persistent alcohol and other drug problems. These same movements have influenced the cyclical ebb and flow of support for addiction treatment. At the 2001 NAADAC conference, I described two emerging movements–a New Recovery Advocacy Movement and a Treatment Renewal Movement–that, through their success or failure, will shape the future of addiction treatment and recovery in America. This article will provide a brief description of the first of these movements.

A Changing Policy Context

Movements ignite when the conditions spawning them reach critical mass. The collapse of 19th century addiction treatment and mutual aid societies and the abandonment of alcoholics and addicts to inebriate penal colonies, the "back wards" of deteriorating state psychiatric hospitals, and the "foul wards" of urban hospitals all set the stage for the founding of Alcoholics Anonymous, Narcotics Anonymous and the rise of advocacy movements (1944-1970) that laid the foundation for our current system of addiction treatment. That achievement was social, (changing public conceptions of addiction and the addict), political (passing landmark federal and state legislation) and technical (developing new addiction treatment modalities).

The successes of the modern treatment and recovery movements were substantial. A federal, state, and local treatment partnership, the recognition of addiction as a treatable (and reimbursable) medical disorder, and the extension of intervention into the family, workplace, school and the courtroom created unprecedented access to addiction treatment and a dramatic expansion of the culture of recovery in America. But dark clouds were forming even as these successes accumulated.

The professionalization and industrialization of the field of addiction treatment led to a loss of such grassroots advocacy functions as community education, recovery resource development,

and policy advocacy. These functions were displaced by paid specialists in public relations, marketing, and lobbying that promoted the institutional interests of newly defined treatment "businesses." The subsequent excesses of the treatment industry in the 1980s led to an ideological backlash that spawned a new wave of therapeutic pessimism about addiction recovery and a financial backlash that dramatically altered the treatment landscape.

As America enters a new century, alcohol and other drug problems are again being restigmatized, demedicalized and recriminalized. Images that portrayed the humanity of addicts and their successful recovery (First Lady Betty Ford) have been replaced by images that evoke fear, ridicule and pessimism about recovery (the frenzied media coverage of Darrel Strawberry and Robert Downey, Jr.). The shift from medical to moral and criminal models of intervention into alcohol and other drug problems grew out of climate of "zero tolerance" filled with highly inflammatory and racialized drug warrior rhetoric. As the doors of hospitals closed, people addicted to alcohol and other drugs entered the criminal justice system in unprecedented numbers (1 ½ million drug-related arrests per year in the U.S., up more than 1 million since 1980).

America's response to alcohol and drug problems has been characterized for more than 250 years by cycles of despair and hope.

When the environment has been most hostile towards alcoholics and addicts, recovering people and their families and visionary professionals have always stepped forward to bring light into this darkness.

An Emerging Movement

More than 5,000 people participate in activities surrounding the Wiping of the Tears Walk across America–a 109 day, 3,800 mile pilgrimage from Los Angeles to Washington, D.C. The journey of a Sacred Hoop of 100 eagle feathers from community to community celebrated the vibrant spirituality, sobriety and healing within Native communities.

In Portland, Oregon the Recovery Association Project negotiates a multi-step action plan with local public health officials to reduce heroin overdose deaths and to respond to the epidemic of Hepatitis C among the city's drug users.

The following is overheard in the reception line following the announcement of the latest Drug Czar's appointment: "Mr. President, my name is ____ and I am a person in recovery."

At Texas Tech University, more than 100 students regularly attend a mid-week recovery celebration meeting. Many are on privately endowed scholarships whose purpose is to provide opportunities for recovering people to attend college within a milieu of supportive of their recovery. As a group, the grade point average of these recovering collegians surpasses that of the general student body by a full grade point.

The Connecticut Community of Addiction Recovery provides a wide variety of support services designed to help people make the transition from addiction treatment to stable, long-term recovery.

The National Alliance for Methadone Advocates pushes an education and advocacy agenda designed to alter the public and professional stigma surrounding medication-supported recovery from narcotic addiction.

In communities across the country, young men in recovery from addiction, wearing T-shirts that read "Amends in Action," meet Saturday mornings to clean up neighborhood parks, replace graffiti with uplifting art, and talk with neighborhood youngsters. They consider this voluntary service a way to make restitution for the wounds they afflicted on their communities when they were addicted.

Two mothers, each having lost a child to a heroin overdose death, wage an unceasing battle to educate others about addiction and the need for enhanced recovery support services.

Two counselors, tired of seeing the fragile recoveries of their clients devoured within drug-saturated social environments,

organize on their own time a network of local recovery homes for people needing sober housing.

In Minneapolis, the Alliance Project brings recovery activists together from all over the country to organize a media campaign to counter the stigma associated with addiction.

In Chicago, recovering people meet with addiction researchers to explore how research can become more recovery-focused in the questions it seeks to answer.

These local stories are part of a larger story: recovering people and their families and "friends of recovery" across the United States joining together to achieve goals that transcend their mutual support needs. Across the country, these new advocates are standing before public officials telling their stories and advocating for the needs of those struggling to achieve stable recovery. Across the country, they are seeking to push the pendulum of public attitudes and to organize new services that will widen the doorway of entry into recovery.

The structure of this emerging movement is somewhat amorphous. There is no single national point of direction for this movement, no national spokesperson, nor any single point of financial support. It is a "movement" only in the shared values, themes and action agendas of these local grassroots organizations, the beginning recognition of each other's existence, and a growing synergy between the members of these local groups.

The movement is emerging from many of the more than 90 local NCADD affiliates who are recommitting themselves to their historical public education and policy advocacy mission. The movement has been energized by the Center for Substance Abuse Treatment's Recovery Community Support Program local grantees. The movement embraces many religious leaders, particularly those in African American communities, who have launched successful addiction recovery ministries. The movement is reflected in the growing "wellbriety" movement in Indian Country. The movement is also fueled by survivors, who after having had family members struck down by or saved from the devastation of addiction, are turning their pain or gratitude into social action. It remains to be seen what form this movement will take as these local groups move toward a national identity and structure.

The core values of these organizations currently reflect a recognition of: 1) the primacy of personal recovery as a platform for political advocacy, 2) the need for authentic, grassroots representation and leadership, 3) the importance of developing local and national leadership, and 4) the value of cultural diversity, to include representation of the varieties of addiction and recovery experience. There is, perhaps more than anything else, a sense that attitudes and policies toward addiction and recovery will change only when local faces of addiction and recovery are brought into the consciousness of American citizens, professional helpers, and policy makers.

The goals of these new and renewed recovery advocacy organizations include:

- portraying alcoholism and addictions as problems for which there are viable and varied recovery solutions,
- providing living role models that illustrate the diversity of those recovery solutions,
- countering any public attempt to dehumanize, objectify and demonize those with AOD problems,
- enhancing the variety, availability, and quality of local/regional treatment and recovery support services, and
- removing environmental barriers to recovery, including the promotion of laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems.

Core Ideas and Strategies

The central idea of the new recovery advocacy movement is not that "addiction is a disease" or that "treatment works" but that addiction recovery is a living reality for hundreds of thousands of individuals, families, and communities. To those who offer a pessimistic or a "one way" view of recovery, this new advocacy movement is

declaring that there are many pathways to recovery. To the NIMBY response to proposals for new recovery homes, this movement offers a reminder that recovery flourishes in supportive communities. In response to the increasingly coercive nature of addiction treatment, this movement is reminding us all that ultimately, recovery is a voluntary process. The new recovery advocacy movement is offering living proof 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). The New Recovery Advocacy Movement is taking a community's historical deficits and turning them into assets through the vehicles of social action and community service.

These ideas come to life through eight strategies that make up the action agenda of most recovery advocacy organizations.

Recovery Organization: developing leadership within communities of recovery so that these groups can declare their existence, express their collective voice, and offer a venue for community service.

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.

Recovery Needs Assessment: identifying obstacles to recovery, evaluating existing service structures, and prioritizing needed recovery support services.

*Recovery Educa*tion: educating lay and professional audiences on the varieties, stages and styles of addiction recovery.

*Resource Develo*pment: cultivating volunteerism within the recovery community and expanding philanthropic and public support for recovery support resources.

Policy Advocacy: championing (through negotiation and social action) stigma-reduction and pro-recovery policies at federal, state, and local levels.

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).

Recovery Research: supporting research that can illuminate the strategies, structures and processes associated with long term recovery.

Implications for Addiction Treatment

If the New Recovery Advocacy Movement sustains its momentum, it will exert many influences on the nature of addiction treatment. It is that very potential that has long made grassroots advocacy movements vulnerable for colonization by the treatment industry. As treatment professionals, we must find ways to support this New Recovery Advocacy Movement without suffocating it. This Movement can succeed only if it sustains its autonomy from the institutional interests that will seek to control it.

While providing a potentially powerful advocate for treatment funding, the New Recovery Advocacy Movement will hold treatment programs to an unprecedented level of accountability in terms of responsiveness and effectiveness. This new movement is calling upon treatment institutions to:

- develop and expand low threshold programs of service engagement,
- identify practices and procedures that inadvertently serve as barriers to treatment initiation and completion,
- move the locus of treatment activity from the institution to the natural environment of those seeking service,
- extend recovery support services beyond the period of acute treatment, and
- expand the service menu to reach a broader spectrum of those experiencing alcohol and other drug problems.

This new movement is confronting us with the fact that addiction treatment has all too often become detached from the larger and more enduring process of recovery. We are being challenged to shift from a treatment paradigm to a recovery paradigm. The most significant import of the New Recovery Advocacy Movement may well be this movement's demand that addiction treatment agencies redefine themselves as "recovery-oriented systems of care." (There will be more on this in a forthcoming article.)

A Call to Service

We are at a critical juncture in our history as a professional field and as a country. It is a time that addiction counselors can participate in history or be passive witnesses of history. The future of addiction treatment and recovery could well be determined by our collective silence or voices. It is time for us to stand up and challenge the therapeutic pessimism and institutional economics that are seeking to once again transfer people with alcohol and drug problems from systems of care to systems of control and punishment. It is time for us to stand up and send an unequivocal message of experience, strength and hope to this culture about the living reality of addiction recovery. It is time we all got involved in the New Recovery Advocacy Movement.

It is time we as addiction counselors stepped out of our offices back into our neighborhoods to help build strong cultures of recovery in every community in America. For those of us who have masked our own recovery status behind a growing veneer of professional credentials, it is time we joined others in offering ourselves as living proof of the proposition that addiction recovery is a reality. Rather than individually lament the progressive loss of treatment and recovery support services, it is time we recaptured the activism that birthed this field in the 1960s and 1970s. There are addiction counselors, young and old, who were born for this moment in history. Some of you reading these words were born to serve this movement. It is time we stepped beyond the demands of our paid roles to volunteer our time, our talents and our personal financial resources to shape this important period in our history.

It is time!

William L. White, MA is a Senior Research Consultant at Chestnut Health Systems (bwhite@chestnut.org) and is the Vice Chair of Recovery Communities United. He is also the author of *Slaying the Dragon: The history of Addiction Treatment and Recovery in America*.

Source Materials

1. Recovery Community Support Program. www.treatment.org and www.ncaddillinois.org

2. White, W. (2000). Toward a New Recovery Movement: Treatment, Recovery, Advocacy. Keynote address, CSAT Recovery Community Support Program Conference.

3. White, W. (2001). The Rhetoric of Recovery Advocacy: An Essay on the Power of Language. www.defeataddiction.org and www.treatment.org.

4. White, W. (2001), News from the Front: The Treatment Renewal and the New Recovery Advocacy Movements. Keynote Address, NAADAC Conference, Portland, Oregon, May

COMING NEXT: The Treatment Renewal Movement



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. (2001). Recovery Summit closing speech. 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, pp. 86-90. Posted at **www.williamwhitepapers.com**

2001 Recovery Summit Closing Speech (St. Paul, MN)

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Where do we go from Here?

It is an honor to be asked to bring the work of these three days to a close. When it became known that I would be speaking at this point in the program, one person asked me if I was going to give an "I Have a Dream" speech. I'm not going to give such a speech this morning, but I did write such a talk for you to adapt and give when you return home to your communities. The "A Day is Coming" talk that we have just passed out is one that you will need to personalize. It strikes many of the major themes that have emerged in this new recovery advocacy movement and is designed to help motivate members of the recovery community to become part of this movement. Take it and adapt it to yourself and your community.

I must tell you that I am somewhat in awe of what our presence here represents. Before I had met and had the pleasure of working with William Cope Moyers, I was interviewed by his father, Bill Moyers, in the spring of 1997 for the "Close to Home: Addiction in America" PBS series. When Bill Moyers asked me to comment on the cycles of despair and hope that seemed to permeate the history of responses to addiction in the US, I told him that I drew great optimism from my study of this history. I told him that when things looked bleakest, recovering people and their families and visionary professionals always rose from the ashes of that despair to forge new treatment and recovery resources. I ended the interview by acknowledging that we were in such a period of bleakness–a period of restigmatization, demedicalization and recriminalization--and that we would likely see a "new recovery movement" emerge in the early 21st century. At that moment, it would have been impossible for me to predict, and more than I could have hoped, that just four and one half years later there would be new and renewed recovery advocacy organizations active all over the country and that I would be standing before 200 recovery activists from 36 states committed to change the way a nation perceives and responds to the

problem of addiction. I want to begin this morning by acknowledging the potential historical import of what we have done together these three days and to tell you that it has been an immense privilege to be part of it.

I once wrote that we needed to act as if we were a movement until we became one. (The image I had in mind was the “Little Engine Who Could” story from my childhood.) It is important to acknowledge that today there is a new recovery advocacy movement that is alive and growing in America. We don’t have to act “as if” today, we ARE. It is important to acknowledge that a core set of ideas and strategies are emerging within this movement. Perhaps most important is how deeply this movement has committed itself to inclusiveness. The new recovery advocacy movement has truly become a coat of many colors representing people of diverse backgrounds and recovery experiences. I am particularly delighted to see the methadone advocates here today. You represent people who have been stigmatized in the society at large and all too often in the recovery community. We welcome you into the heart of this movement and ask you to educate us all about the legitimacy and durability of medication-assisted recovery.

The response to the work of those in this room from our own recovery communities has moved from hostility, skepticism and apathy to growing interest, support and involvement. We are becoming visible in our local communities and our voices are beginning to be heard in the policy arenas. Our work to date merited the attention of the many foundations and private philanthropists who supported our work these past three days. We have much to be proud of today.

All movements are about struggle, and we will have some difficult days ahead. In bringing our work here to a close, I want to link the campaign we have proposed to the larger recovery advocacy movement of which that campaign is a part. I want to touch on some larger issues that we will be continuing to struggle with in the coming days and that will impact this campaign that we have planned.

There is the issue of the boundaries of this movement. As we gain more visibility, many groups will want to hitch a ride on our star. We must carefully define the boundaries of who we are and who we are not. We must define what are and are not our issues and we must find a way to draw from all of our experiences to set this boundary. These discussions must go on at all levels of this movement and will be among the most important decisions made in the history of this movement.

The question of the structure of this movement has been, and will continue to be, a point of discussion, competition and controversy. As of this moment, I am advocating a minimalist approach to this structure. I don’t believe we need a new structure to lead this movement, but I think we may need new frameworks to integrate our activities, to communicate with one another, and to support one another. My vision for this is a communication and service structure not unlike those that have worked well for many mutual aid societies in American history. It is important that the resources and leadership for this movement remain to the greatest extent possible at the grassroots level.

It is also time we talked explicitly about the role of family members in this new recovery advocacy movement. They have been with us since our organizations were founded, and they have often served important leadership functions. But in some places they have not been formally welcomed in that role. I think it is time we welcomed family members as equal partners in this movement and asked them to stand beside us in leadership roles at all levels within this movement.

There is the role of professionals and treatment institutions. Visionary professionals have always been part of recovery advocacy movements. I think we need to invite them into this movement as well, but I think we need to continue to make sure that this movement stays recovery focused and does not become the marketing arm that supports the financial interests of the treatment industry. Treatment and recovery are not the same, and we will support the treatment industry only to the extent that it demonstrates greater concern for the progress of its clients than its institutional profits.

There is the role of money in this movement–a subject close to many of your hearts as some of you anxiously awaited the announcement of CSAT's RCSP funding decisions this past week. I've written that too much money, too little money, ill-timed money and tainted money could kill this movement, and I must confess that I am already concerned about the growing dependence of this movement on federal funding. Recovery advocacy in the 1940's, 1950s and 1960s evolved into the treatment industry of the 1970s and beyond and, by doing so, lost its education and advocacy focus. We must make sure that we remain a movement and, if we are successful, resist the temptations of professionalization and commercialization. Strong organizations like the Recovery Association Project in Portland, which did not receive continued CSAT funding, have a special destiny to show us how grassroots recovery advocacy organizations can be sustained without primary and continued reliance on such funds.

The campaign we have outlined here is an important part of the larger recovery advocacy movement, and I would be remiss if I didn't acknowledge the important role that Willam Cope Moyers, Jeff Blodgett and their respective organizations have played in making this possible. To Jeff I want to give a particular thanks for all his contributions and publicly say to him that we will let him take on another important job this next year but we will not let him leave this movement. I also want to add my words of thanks for the support of the many individuals and foundations, particularly the Robert Wood Johnson Foundation, that made this meeting possible.

We have selected the seeds for this campaign; it is time that we went home and planted them. When you get home and ask others to join us in this campaign, some will say they can't help with this movement because they are too old. Remind them that Handsome Lake was 65 years of age in 1799 when he launched a sobriety-based revitalization movement among the Six Nations Iroquois Confederacy. Tell them how this man who was near death used his own sustained recovery as a springboard to bring sobriety to thousands of Native Americans.

Some will say they are too young. Remind them of the Reverend Alvin Foltz who entered recovery as a teenager and became known as the "saved drunkard boy" and one of the 19th centuries most articulate and effective temperance organizers. Remind them that tat the ignition point of the civil rights movement, it was the youngest, not the oldest, minister asked to lead this movement. Remind them that the young King called to lead this movement changed a nation.

Some women will say that the multiple role demands of their lives leave little room to support such a movement. Remind them of the crucial roles women have played in the history of social movements. Remind them that the name of Martin Luther King, Jr., might have remained unknown if it were not for the courage of Rosa Parks.

Some members of the lesbian, gay, bisexual and transgender community will say that they are too busy fighting their own stigma issues to participate in the recovery advocacy movement. Remind them of a most remarkable human being (and lesbian woman) who dreamed in 1944 that she could change the way a nation viewed alcoholism and the alcoholic. Tell them

how Marty Mann built an organization that opened the doors of treatment and saved hundreds of thousands of lives. Tell them that her legacy is today being threatened.

Some will say their background disqualifies them. Remind them of Jerry McAuley and Malcom X whose religious transformations, recoveries from addiction, and activist visions were born in their jail cells. Tell them how each of these men, separated by a century, went on to lead thousands into lives of sober self-respect and dignity.

Some will say they are ill suited to put a face and voice on recovery. Remind them that the greatest social movements have been sparked and supported by the most imperfect of people. Remind them that their face and their voice will be part of a choir of thousands who like themselves owe a debt of enormous gratitude.

Some will say that they and their families would be injured if they stepped forward. Acknowledge that stigma is real and that we don't need everyone in recovery to play this public role. Remind them that there are hundreds of ways they can support this movement outside the view of the camera.

I have had the pleasure of being with many of you in your local communities these past few years, and I have had an opportunity to observe your work. We don't need all individuals and families in recovery for this movement to succeed, but we do need a deeply committed vanguard. You have been that vanguard and I want to close by honoring your passion and your perseverance. It is time for us to leave here and to go back to our communities. It is time for us to leave here and create the future of recovery in America.

There are many stories passed down as part of the oral history of the civil rights movement, and I would like to close with one I first heard in 1967. It was of a day in a Southern city in which hundreds of people were marching in defiance of a court order. When they reached a crest of a hill what faced them ahead was a sea of baton-slapping police officers and barely restrained police dogs. It is said that a terrified silence fell over the marchers as each marcher visualized what was about to unfold. The spell was broken by the weathered but calm voice of one of the oldest marchers who said clearly and simply, "Let's go make some history." Our meeting here has been important only to the extent that we leave here and sustain this movement in communities all across America. So I leave you with these words, "Let's go make some history."

White, W. (2001) A Day is Coming: Visions of a New Recovery Advocacy Movement. Distributed at the Recovery Summit, October 4-6, 2001, St. Paul, MN. Posted at www.facesandvoicesofrecovery.org. 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, pp. 91-100.

A Day Is Coming:

Visions of a New Recovery Advocacy Movement

It is an honor to be able to share some thoughts with you about the recovery advocacy movement in America. I have had the privilege of working with many of the grassroots organizations that are the backbone and heart of this movement. Recovering people and their families, friends and professional allies are once again organizing to change the way this country views addiction and the potential for recovery. It is indeed an exciting time within communities of recovery in America.

There Was a Day

I want to begin my remarks by talking about our past. There is much we can learn by sitting at history's feet. Comedian Lilly Tomlin once observed that, if we listened, maybe history wouldn't have to keep repeating itself. I have come to recognize the profound wisdom in her words.

There was a day in the late 19th century when an elaborate network of recovery support groups and addiction treatment institutions dotted the American landscape. There were Native American recovery circles, the Washingtonians, the fraternal temperance societies and the reform clubs. There were recovery-oriented inebriate homes, medically-oriented inebriate asylums, for-profit addiction cure institutes, and religiously-oriented inebriate colonies. In that time, physicians in the American Association for the Cure of Inebriety proclaimed to all the world that addiction was a disease that could be either inherited or acquired and that this disease was one from which people could fully recovery. On that day, recovery activists, alone and in organized groups, offered themselves as living proof that recovery from addiction was possible.

That day vanished in the opening years of the twentieth century, drowned in a wave of cultural pessimism that closed addiction treatment institutions and sent recovery groups into hiding. The demise of America's first era of institutional treatment and recovery support groups is a stark reminder that we can take nothing that exists today for granted.

As America's 19th century institutions and support groups collapsed, a new sunless day emerged. That day, less than a hundred years ago, witnessed addicted people locked away for years in rural penal colonies. Americans, believing that alcoholics and addicts were a "bad seed" that threatened the future of the society and the human race, passed laws providing for their mandatory sterilization. That was a time when people who had yet to achieve recovery filled the "cells" of "foul wards" in large city hospitals, and they were the lucky ones, as most hospitals refused their admission. That was a day when alcoholics and addicts spent their most despairing hours in city drunk tanks. That was a day when those not yet in recovery died in the streets and were swept up like discarded refuse. That was a day when alcoholics and addicts

languished in the snake pits of aging state psychiatric hospitals. That was a day when alcoholics and addicts were subjected to brain surgery and shock therapies and every manner of drug insult--all thrust upon them in the name of help. That was a day when family members died a thousand emotional deaths in their desperate, unrelenting search for help for an addicted spouse, parent, sibling or child. Those days of professional condescension and public contempt were not so long ago.

The remnants of those dark days were present in the earliest years of my own entrance into the worlds of addiction treatment and recovery. In the 1960s, I witnessed alcoholics and addicts languishing in the most cold and callous of institutions. I have no words to convey the feel or smell of such places, places that conveyed in a thousand ways that you were not human, places that sucked the hope out of all condemned to live in them. I have vivid recollections of local community hospitals refusing to admit alcoholics and addicts for treatment of acute trauma: such people were perceived as not morally worthy to fill beds reserved for those who were "really sick." Working as an outreach and crisis worker, I have nightmarish recollections of the bodies of the addicted hanging from torn sheets in jail cells, and my own desperate attempts to find the words to communicate with families who had long feared a visit such as mine.

The invasive treatments--the shock therapies, the drug insults, the prolonged sequestration--are not ancient tales. I recently interviewed a woman who was hospitalized for acute alcohol poisoning in 1971. She and her family were given two treatment choices: a one-year commitment in a state psychiatric hospital or brain surgery--a lobotomy--that they were told would remove her craving for alcohol. The woman herself thought the surgery a better alternative than being locked up for a year. But a chance encounter between her father and a man in recovery brought a woman from Alcoholics Anonymous to her bedside and the beginning of what has now been more than three decades of sanity, sobriety and service. Her story tells us that we are little more than a generation away from these infamous days. Her story also hints at what happened to open the doors of recovery.

Those Days Ended

Those dark days passed not by accident but because small handfuls of people in communities across the country said, "No More!" and spent their lifetimes destroying drunk tanks and drunk jokes. Those days ended because a desperate stock analyst reached out to a desperate physician and started a fellowship of recovering alcoholics whose influence embraced the world. Those days disappeared because of the vision of Marty Mann, who dared to dream in 1944 that she could change the way a nation viewed alcoholism and the alcoholic. Those days vanished because a senator, in gratitude for his own recovery, challenged a country to create local alcoholism education and treatment centers accessible to all of its citizens. The odds against success were enormous, but these remarkable human beings spent their lives building the world of addiction treatment and recovery that has touched the lives of many of us in this room. The bleakest days for the addicted in America passed because men and women looked beyond their own recoveries to advocate for the needs of others. The foul wards and drunk tanks and brain surgeries gave way to new treatment and recovery resources because real men and women made these changes happen. Consider for a moment what their lives rendered.

Imagine the degree of fulfillment that Dr. Robert Smith and Bill Wilson experienced at the sunset of their own lives as they reflected on the fruits of their work. Imagine what it must have been like for Sister Ignatia, who after working with Dr. Bob detoxifying early AA members, was later asked to address the 25th anniversary convention of AA in 1960. Imagine what this frail,

humble woman must have felt as she stood and looked out at 17,000 sober and grateful alcoholics standing before her. Imagine what Marty Mann, after decades of barely acknowledged effort, must have experienced seeing the rise of local alcoholism treatment programs across the country. Imagine the import of such fulfillment in a woman who before her own recovery had repeatedly tried to kill herself. Imagine the fullness of lives that profoundly touched so many people.

The days of shame turned into days of hope because hundreds of unnamed men and women devoted their lives to changing the way a country looked at a disorder and those who suffered from it. The fruits of their work were indeed remarkable. Hundreds of thousands of people rose from the dead to live full lives because of the resources these people created. The national network of prevention and treatment programs are all part of their legacy as are the diversion programs in the criminal justice system and the early intervention programs in the workplaces and schools. By the early 1980s, it looked as if the dreams of these pioneers would be fully realized, but other forces were lurking in the background.

A Shameful Regression

Today, the world they created is being dismantled, and their advances are being threatened. Three ominous changes threaten this progress.

First, America is again restigmatizing those addicted to alcohol and other drugs. The positive images of long-term recovery (e.g., First Lady Betty Ford) are being replaced by what the public perceives as spoiled celebrities using "rehab" to escape the consequences of their latest indiscretion. Treatment and recovery are degraded through such images. The portrayal of addiction as a medical disorder suffered by sons and daughters, mothers and fathers, and brothers and sisters was replaced in the 1980s and 1990s by the worst racial and class stereotypes—stereoptypes that linked addiction with crime, violence, and insanity. Alcoholics and addicts became not people deserving of compassion and help, but people to be feared and who were deserving of punishment. Thousands of celebrities will celebrate recovery anniversaries today and one will be arrested for possession of heroin. Which story do you think will fill the television screens this evening?

Second, after working for decades to place alcohol and other drug problems in the medical and public health arenas, we are now removing them from these very categories. Health care coverage to pay for addiction treatment continues to erode. Many, if not most, of the hospital treatment units have closed. The management of addiction is moving to non-medical settings and toward a focus on control of the addict and addiction-related costs rather than personal recovery.

Third, alcoholics and addicts are filling our courts, jails and prisons in unprecedented numbers. There are now more than one and one half million drug-related arrests per year in the U.S., up more than 1 million since 1980.[1] The number of drug offenders in state correctional facilities has risen from 38,900 in 1985 to more than 227,000[2] in 1997 and drug offenders in Federal prisons have risen from 9,482 in 1985 to more than 55,000 in 1996.[3] I would be remiss

[1]Department of Justice, Office of Applied Studies: 1.6 million drug-related arrests in 1998, up more than 1 million arrests per year since 1980.

[2]In 1997, Department of Justice, Office of Applied Studies.

[3]In 1996, Department of Justice, Office of Applied Studies.

if I did not talk about the racial disparity buried within these numbers. African Americans constitute only 15% of illicit drug consumers, but they make up 37% of those arrested for drug violations, 42% of drug offenders in federal prison and 60% of felony drug offenders in state prisons.[4] A recently released Human Rights Watch report[5] revealed that in states like Illinois, a young African American male is more than 50 times more likely to go to jail for a drug offense than is his Caucasian counterpart arrested for the same offense. The rise in addiction-related stigma and the transfer of alcoholics and addicts from treatment centers to correctional centers are deeply entwined with issues of gender, social class and race. We can't expose the former without confronting the latter.

A Day is Coming

So where does that leave us? What should recovering people, impacted families and the friends of recovery do about this bleak situation? What should all people of good will concerned about this problem do? They should do that which is so uniquely American: Organize and change it! And that is precisely what is happening.

We are reaching a critical milestone in the history of recovery in America. We are approaching a crossroads that will dictate the fate of hundreds of thousands of individuals and families and thousands of communities. Recovering people know the deep truth in the adage that it is darkest just before the dawn. That darkened horizon is clearly evident across America today, but there IS a dawn arising. Emerging from that dawn are not government agencies or treatment professionals but a new generation of wounded healers. Recovering people and their families and friends are once again on the move--once again coming together not just for mutual support, but to widen the doors of entry into recovery through education and advocacy. A New Recovery Advocacy Movement is being born in this country. From Wall Street to Bourbon Street, from South Carolina to South Central, from Indian Country to the barrio to the wealthiest suburb, people are coming together to challenge the restigmatization, demedicalization and recriminalization of addiction in America. They are coming together to publicly reaffirm the hope for recovery from addiction.

In 1976, 52 prominent Americans publicly proclaimed their recovery from alcoholism in a landmark event sponsored by the National Council on Alcoholism called Operation Understanding. A day is coming when that number will swell to 5,000 and 50,000 and then to 500,000--all offering testimony about the transformative power of recovery. A day is coming when we will gather at state capitals and in our nation's capital and you will see recovering people in every direction as far as the eyes can see--all offering themselves as LIVING PROOF that recovery is not just a possibility but a living reality. On that day, young people with a month of hard-earned sobriety will march beside men and women with 50 years of sobriety. On that day, families will walk to honor their survival as a family and to celebrate their own personal

[4]NIDA Household Survey on Drug Abuse, 1998; US Department of Justice, Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics, 1998. Also http://www.csdp.org/factbook/racepris.htm

[5]Key Recommendations from Punishment and Prejudice: Racial Disparities in the War on Drugs. Washington, D.C. Human Rights Watch, 2000.

recoveries. On that day, those who have lost a loved one to this disease will walk to save others. On that day, AA and NA members will walk beside SOS and WFS members. Those in supported recovery will walk beside those in solo recovery. Those from therapeutic communities will walk beside those in methadone-assisted recovery. On that day, we will set aside our differences and march arm-in-arm as a multi-hued network of local communities of recovery.

In 1893 an addiction mutual aid society organized itself under a banner that read: "The Law Must Recognize a Leading Fact: Medical Not Penal Treatment Reforms the Drunkard." A day is coming more than a century later when we will protest outside jails and prisons to proclaim that same message. A day is coming when addicted people who fill those prisons will organize their own recovery advocacy organizations. In embracing recovery, they will go on strike--withdrawing the bodies and souls that feed the economies of these institutions.

A day is coming when recovery from addiction will be viewed not as a curse to be masked and hidden, but as a cause for celebration and a gift to be shared with the world. A day is coming when for one moment in the history of this country, recovering people will stand together and offer themselves as living proof of the fulfilled promises of recovery. To those around us, we will offer our gratitude for your forbearance and forgiveness. To those still suffering, we will proclaim:

> You represent our past just as we represent a future that could be yours. You have been part of the problem; add your voice to ours and become part of the solution.

Before That Day

We have work to do before that day can arrive. Movements that have created the most dramatic and enduring social change often began with an alteration of personal consciousness. The message from these movements is that we must change ourselves before we can change the world. We cannot confront stigma in the outside world until we discover how stigma works within us, and our relationships with the world. The internal consequences of such stigma must be excised before one experiences the worthiness and the power to confront its external source. We must excise that stigma so that we can move beyond our own healing to find our indignation, our outrage, and our sorrow that people who could be recovering are instead dying. We have to move beyond our own serenity and retrieve the fading memories of our own days of pain and desperation. Before that day, we need leaders who will jar us from our complacency and challenge us to hear the cry of the still suffering. Stigma is real, but we need to confront the fact that our own silence has contributed to that stigma. Listen to the words of Senator Harold Hughes who before he died proclaimed:

> *By hiding our recovery we have sustained the most harmful myth about addiction disease--that it is hopeless. And without the example of recovering people it is easy for the public to continue to think that victims of addiction disease are moral degenerates--that those who recover are the morally enlightened exceptions....We are the lucky ones, the ones who got well. And it is our responsibility to change the terms of the debate for the sake of those who still suffer.*

How can addicted people experience hope when the legions of recovering people in this culture are not seen or heard? Where is the proof that permanent recovery from addiction is possible? We need a vanguard of recovering people to send an unequivocal message to those still drug-enslaved that they can be free. We need a vanguard willing to stand as the LIVING PROOF of that proposition.

Before that day, we will need to find ways to link those from all kinds of recovery backgrounds into a community of recovery. This is not an AA or Al-Anon movement or a NA movement or a WFS movement or an addiction ministry movement. It is a RECOVERY movement. The failure of various recovery groups and individuals in solo recovery to see themselves in terms of "we" is the most significant obstacle to fully realizing the potential of the New Recovery Advocacy Movement. We must get to know each other not as AA or Al-Anon members or NA members or SOS members, but as members of a recovery nation, each of whom contributes to its diversity and vitality. It is only by constructing our own identity as people in recovery and transcending the categories that separate us that we can transform our personal experiences into a new recovery advocacy movement. It is time we celebrated this coat of many colors that the recovery community has become. Our goal must not be to speak with one voice, but to share a recovery identity out of which we will speak with thousands of voices that achieve harmony on one issue: the potential for transforming and enduring recovery from addiction.

Before that day comes, we will need to find the systemic roots of stigma. We will need to confront the fact that addicted people have become the raw materials that run whole professional and community economies. Some of these institutions operate, not to help the addict, but to protect and extend their own institutional influence. Stigma provides the ideological justification for the perpetuation of these institutional economies. We need to either transform these institutions (shift them to a focus on care and recovery rather than control and profit) or advocate their closure. Confronting these systemic forces will be more about power and influence than about changing attitudes.

We must also find the personal roots of stigma. There are whole professions whose members share an extremely pessimistic view of recovery because they repeatedly see only those who fail to recovery. The success stories are not visible in their daily professional lives. We need to re-introduce ourselves to the police who arrested us, the attorneys who prosecuted and defended us, the judges who sentenced us, the probation officers who monitored us, the physicians and nurses who cared for us, the teachers and social workers who cared for the problems of our children, the job supervisors who threatened to fire us. We need to find a way to express our gratitude at their efforts to help us, no matter how ill-timed, ill-informed and inept such interventions may have been. We need to find a way to tell all of them that today we are sane and sober and that we have taken responsibility for our own lives. We need to tell them to be hopeful, that RECOVERY LIVES! Americans see the devastating consequences of addiction every day; it is time they witnessed close up the regenerative power of recovery.

It is not enough to come together and advocate for our own needs--to focus on the needs of those already in different stages of recovery. This movement must keep its eyes on ways the doorway of entry to recovery can be widened for those still suffering. And perhaps in the end it is not even enough to widen this door. Perhaps there is a larger agenda lurking in the

background--the agenda of creating a better community and a better world--to take some of what has been learned in recovery and infuse that into the civilian community. To America, we say:

> *You can help save us, but we can also help save you. We are the ones who courted, yet cheated, the grave. In our darkest hours, we discovered some things of value that through us you can rediscover.*

Some of you don't know it yet, but you were born to play a role in this movement. To those with long-tenured recovery, we need your wisdom, your stability, your hard-earned serenity. To those new in recovery, we need the freshness of your pain and the fervor of your passion. To those family members who have lived through the devastation of addiction and the demands of recovery, we need your love and patience and invite you as equal partners into the leadership of this movement. To the children who have lived in the shadow of parental addiction, we need your courage to break the intergenerational transmission of these problems. To those who have lost someone to addiction, we call on you to give that lost life meaning by wrapping it within your own story and passing it on to others. To professional helpers and other friends of recovery, we invite your involvement and challenge you to help us create recovery-oriented systems of care within local communities across the country.

I know some of you will see yourselves as unfit for this calling. You will identify an endless list of frailties and inadequacies that disqualify you from serving this movement. But if there is anything that history tells us, including the history of recovery, it is that the most perfect message can be delivered by the most imperfect of messengers. We have freed ourselves; it is time we freed our neighbors and our communities. There is much that we have yet to learn, but as a people we do know something about deliverance and liberation. A day is coming when we will help free America with the truth of our stories.

When will that day arrive? The dawn of that day is here but we must seize it! I invite you and challenge you to become part of this new recovery advocacy movement by supporting local recovery advocacy organizations with your time, your talents and your money. I invite you to find opportunities to tell your stories to those who know little about addiction or recovery. And I invite you to become an activist in advocating pro-recovery policies in every venue of influence you can reach. As Senator Hughes suggested, our own salvation as individuals and families bestows upon us a debt of obligation and an opportunity for service. When a vanguard of recovering people and their families step forward to pay this debt and accept this mantle of service, that new day will have arrived.



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. (2001). The rhetoric of recovery advocacy. 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, pp. 37-76. Posted at **ww.williamwhitepapers.com**

The Rhetoric of Recovery Advocacy:

An Essay on the Power of Language [1] [2]

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The difference between the right word and the almost right word is the difference between lightning and the lightning bug. --Mark Twain

To kill a dog you must call him crazy. --Ethiopian Proverb

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

In an earlier communication, I described the rise of a New Recovery Advocacy Movement and identified lessons that could guide this movement that were drawn from the history of earlier addiction mutual aid societies and recovery advocacy organizations. If successful, the New Recovery Advocacy Movement will create a fully developed recovery advocacy culture--a culture with its own history, institutions, folk heroes, "kinetic" ideas, core values, key roles, images, symbols, language, art, music and rituals. It will use the collective elements of this culture to extend its influence into the larger society in which it is nested. It is, in part, through seeding the

[1]I would first and foremost like to acknowledge the assistance of Ernest Kurtz whose continued insights and feedback on my New Recovery Advocacy Movement papers deserve words of gratitude that are beyond my ability to express. Others who provided helpful comments on an earlier draft include Jeff Blodgett, Alex Brumbaugh, John Magisano, and Bob Savage.

[2]The historical references in this article are drawn primarily from: White, W. (2004) The Lessons of Language: Historical Perspectives on the Rhetoric of Addiction. In: Tracy, S. and Acker, C. *Altering American Consciousness: Essays on the History of Alcohol and Drug Use in the United States, 1800-1997.* Amherst, MA: University of Massachusetts Press, pp. 33-60.

larger society with these elements that advocacy movements achieve the changes that they are seeking. This paper will explore how one element of the recovery advocacy culture, that of language, can be used as a tool of self-transformation, constituency mobilization, and social and political change.

To begin this discussion, we should acknowledge that the childhood adage, "sticks and stones can break my bones, but names can never hurt me", is patently untrue. Words, and the meanings with which they are imbued can achieve accuracy and relevance or they can transmit dangerous stereotypes and half-truths. They can empower or disempower, humanize or objectify, engender compassion or elicit malignant fear and hatred. Words can inspire us or deflate us, comfort us or wound us. They can bring us together or render us enemies. Put simply, our lives are profoundly shaped by the words we apply to ourselves and those that come to us from others. The shaping/transforming/deforming power of labels is particularly compelling: Educators have long noted the self-fulfilling power of labeling children.

For more than two centuries, addicted and recovering people in America have been the object of language created by others. People experiencing severe and persistent alcohol and other drug problems have inherited a language not of their own making that has been ill suited to accurately portray their experience to others or to serve as a catalyst for personal change.

When historically stigmatized peoples create social movements to free themselves from their "stained identities" and to alter the social conditions within which they are stigmatized, they often begin with processes of renaming, story reconstruction and story telling that are designed to alter their perceptions of themselves individually and collectively.[3] Such processes identify and diminish the effects of internalized stigma (shame, hopelessness, helplessness, passivity) and make individual and collective action possible. In this emergence, stigmatized peoples reject labels applied to them by others and replace this language with words of their own choice or creation.

Focusing on the subtle meaning of words--rejecting some while embracing others--is far more than a matter of shallow political correctness. It is about changing the way addicted and recovering people see themselves and are seen by others. It is about changing the language that affects social policies and is in turn affected by those policies. Changing language is a way to personally and culturally close one chapter in history and open another.

The New Recovery Advocacy Movement is faced with several choices. It can continue to stigmatize its members by using a poisoned language incongruent with its mission and core values. The Movement can try to rehabilitate the existing language by reframing it or squeezing as much poison out of it as possible, or the New Recovery Advocacy Movement can coin and promulgate a new pro-recovery vocabulary.

What I hope to do in this brief essay is to offer some historical and personal reflections on the words that have been the central tools in conceptualizing both alcohol and other drug-related problems and their resolution. My goal is to stimulate discussion about the layers of potential meaning that fill much of this language. For the New Recovery Advocacy Movement to be "new," it will need a fresh and dynamic language to free it from the echoes of the past. In this

[3]This renaming is evolutionary through the life of such movements, e.g., the most degrading of epithets gave way to Negro, then Black, then African American, and the more recent and embracing People of Color. The New Recovery Advocacy Movement will likely go through similar processes of language evolution.

essay, I will call for the abandonment of some long-used words, the careful re-examination of other words, and the elevation of yet other words to the center of the New Recovery Advocacy Movement.

Recovering people need a pro-recovery language to interpret their own experience, to communicate with each other, and to give the larger culture more accurate and respectful words to depict the nature of severe and persistent AOD problems and how those problems may be resolved. By claiming the right to speak publicly and to frame their experience in their own language, recovering people are politicizing (in the best sense of this term) what up until now have been their own private experiences. Words have been used to wound addicted and recovering people--to declare their status as outcasts. Words can also be used to heal addicted and recovering people and invite them into fellowship with each other and the larger society.

Words/Concepts We Need to Abandon

These words are razors to my wounded heart.

--William Shakespeare

Communities of color have shed (or reframed) other-applied names and re-christened themselves as they came of age and matured as communities. For isolated individuals to come together as a group, they must come to see and define that which characterizes them as a distinct people. When those distinguishing qualities have been defined by others in terms of disrespect and disrepute, these terms must be cast away and new labels elicited from their collective aspirations. All modern rights and liberation movements have understood this need to shape their own language and images. The New Recovery Advocacy Movement, as it moves towards its own self-examination and coming of age, will, like the movements before it, confront this issue of language. As a contribution to this work, I would like to recommend that several words/phrases be cast aside by the New Recovery Advocacy Movement.

Abuse

Of all the words that have entered the addiction/treatment vocabulary, “abuse” is one of the most ill-chosen and, as Mark Keller once characterized it, pernicious. First of all, to suggest that the addict mistreats the object of his or her deepest affection is a ridiculous notion. Alcoholics do not “abuse” alcohol (mixing Jack Daniels with fruit punch does come to mind here) nor do addicts “abuse” drugs. Addicts, more than anyone, treat these potions with the greatest devotion and respect.

In addition to being technically incorrect, references to alcohol/drug/substance “abuse” drip with centuries of religious and moral censure. 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”.[4] Terms such as *alcohol abuse*, *drug abuse*, *substance abuse* all spring from religious and moral conceptions of the roots of severe alcohol and other drug problems. They define the locus of the problem in the willful choices of the individual, denying how that power can be compromised, denying the power of the drug, and denying the culpability of those whose financial interests are served by promoting and increasing the frequency and quantity of drug consumption.

[4]Lender, M. (1973). Drunkenness as an Offense in Early New England: A Study of >Puritan= Attitudes. *Quarterly Journal of Studies on Alcohol,* p 353.

Abuse has long implied the willful commission of an abhorrent (wrong and sinful) act involving forbidden pleasure, e.g., the historical condemnation of masturbation as *self-abuse*.[5] The term has also come to characterize those of violent and contemptible character--those who abuse their partners, their children or animals. It was the very weight of this history that led the National Commission on Marihuana and Drug Abuse to criticize the term "drug abuse" in 1973. The Commission suggested that "continued use of this term with its emotional overtones, will serve only to perpetuate confused public attitudes about drug using behavior." The term gained even greater prominence following the Commission's report.

To refer to people who are addicted as alcohol, drug or substance *abusers* misstates the nature of their condition and calls for their social rejection, sequestration and punishment. There is no other medical condition to which the term "abuse" is applied. If we truly believe that addiction is a serious health problem, then why do we continue to have departments and centers of substance abuse? The terms *abuse* and *abuser* should be now and forever be abandoned in discussions of people with severe and persistent alcohol and other drug-related problems.

Self-help

It is common to refer to Alcoholics Anonymous, Narcotics Anonymous, Women for Sobriety and other such organizations as "self-help" groups or refer to a broader "self-help" movement. Ernest Kurtz and William Miller have quite insightfully noted that such designation conveys a "pulling-oneself-up-by-the-bootstraps" image of addiction recovery. They noted, in contrast to this image, that people who seek help from such groups usually do so as an acknowledgment that all attempts at self-help have failed.[6] Recovery in many support groups is not "self-help" but the utilization of resources and relationships beyond the self. As such, the New Recovery Advocacy Movement organizations could more correctly depict these groups as "recovery support" or "mutual aid" groups.

Untreated Alcoholics / Untreated Addicts

In the lobbying for parity (the funding of addiction treatment on par with other medical disorders), one endlessly hears about the personal and social costs of "untreated addiction" and about the number of "untreated alcoholics" and "untreated addicts" that are now denied access to treatment. While such language well-serves the parity argument, it implies that the pathway into recovery inextricably requires passage through professionally-directed treatment. This is simply not true. Referring to people still suffering from addiction as "people not yet in recovery" is a far more accurate and preferable term than depicting such people as "untreated."

Consumer

The term, *consumer*, when used as a synonym for recovered and recovering people, is a misnomer. Like "untreated alcoholics" or "untreated addicts", the term implies that all people in recovery have been, or need to be, consumers of treatment services. By speaking of "consumer representation", the language narrows participation in policy development to people who have participated in treatment rather than to the larger pool of addicted and recovering/recovered

[5]Renaud, J. (1989). Substance Abuse is Language Abuse. *The Counselor,* July/August 7(4):26-27. Others who have argued against the application of "abuse" to severe and persistent alcohol and other drug problems include James Royce, Mel Schulstad, Neil Scott, and the Society of Americans for Recovery.

[6]Miller, W. and Kurtz, E. (1994). Models of alcoholism used in treatment: Contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, pp.159-166 (March).

people. Those who seek treatment and those who do not seek treatment constitute different populations of people, making it impossible for the former to speak for the experiences and needs of the latter. (If, for example, we want to ascertain how to reach those who need but have never utilized treatment services, we should conduct focus groups with them rather than ask the most successful treatment graduates how to reach that group.) The focus should be not on "consumer representation" but on "constituency representation" or "recovery representation" and all that the latter terms imply by way of diversity.

The Language of Self-Pity

Any new movement must define itself within the times and social context in which it finds itself. Over the past half-century, Americans have experienced social movement after social movement--each vying for attention, each claiming an emotional debt, each seeking redress for past wrongs. As a result, America is today suffering from compassion fatigue. Its tolerance for old and new demands is so low that any new movement risks inciting a rapid backlash of derision that could hurt the very cause it seeks to promote. Great care must thus be taken in using the rhetoric and methods of earlier movements.

America has lived through the "me decade" of the 1980s and the security of widespread prosperity of the 1990s, but a new century is opening with many themes worth noting: heightened financial insecurity, a growing sense of depersonalization and diminished sense of control over most aspects of our lives, and a diminishment of respect for professions that historically protected the vulnerable (physicians, clergy, lawyers, etc.). The New Recovery Advocacy Movement must position itself in this cultural stew.

Any language that even hints at self-pity will doom the legitimate aims of this movement. While the New Recovery Advocacy Movement, like its predecessors, is, at least in part, a rights movement, this is not the moment to push such issues to the fore. What is needed are themes that strike strong emotional cords in the culture at large. What will get America's attention is not a call for sympathy or redress of past and present insults to addicted and/or recovering people, but articulating themes of gratitude, responsibility and service. (See later discussions). What will grab the attention of the culture is a movement whose members are coming together not in supplication but in service; not asking for something, but offering something; not advocating for themselves, but for others; not acting as individuals, but in communion; and not seeking solutions through formal institutions but through the community itself.

Words/Concepts We Need to Discuss and Debate

While some words may need to be changed, others need to be carefully analyzed and discussed. A few of my nominations in this category are: alcoholic/addict, disease, treatment works, stigma, recovered/recovering, relapse, and enable.

Alcoholic/Addict

How shall we refer to this condition in which people in spite of their best intentions continue to consume psychoactive drugs at a frequency and intensity that destroys them and those around them? How shall we refer to people with severe and persistent alcohol and other drug-related problems? To sort out the kind of language that will best serve the New Recovery Advocacy Movement requires that we raise an important point: Language that has a high degree of meaningfulness and usefulness in intra-group communication might have unforeseen, harmful consequences in extra-group communication. Positioned on the boundary between the recovery world and the civilian world, the New Recovery Advocacy Movement may need to use one

language when it turns inward and another language when it turns outward to communicate with the larger society.[7]

The terms *alcoholic* and *addict* have provided people with severe and persistent alcoholic and drug problems an important set of tools to understand the specific nature of their problem, to take ownership of that problem, and to understand where they should seek help for that problem. The words have been an important part of addict-physician and addict-addict communication for more than a century. The terms *alcoholic* and *addict* are foundational terms in Alcoholics Anonymous and Narcotics Anonymous and in many addiction treatment programs, even though *alcoholism* and *alcoholic* are no longer used as official diagnoses. The words have had, and will continue to have, value in helping individuals understand aspects of their experience and their own personhood that would otherwise be inexplicable and to use this understanding to resolve their alcohol- and drug-related problems.

These same terms used in common discourse outside therapeutic and recovery circles have done something of a disservice. They have contributed to the tendency to define all alcohol- and drug-related problems within the rubric of the clinical entities of alcoholism and addiction. Because of the moral stigma attached to these severe conditions, the labels have themselves become an obstacle to people seeking resolution of AOD problems in a timely manner. When people experience problems with alcohol and other drugs, they and those around them seem to be fixated on the question, "Am I (or, Is ___) an alcoholic?" It is only natural that such a stigmatized label would be resisted. The focus in this situation shifts from the problem to the fear of the label and its stigmatizing consequences. Embracing large numbers of people within the rubric of "alcoholic" or "addict" also conveys the impression that these individuals are the same. Referring to people by their shared medical diagnosis assumes any important differences have been lost to the homogenizing influence of their disorder. "Disease first" language, as opposed to "people first" language, obliterates individual differences and depersonalizes those to whom the label is applied.

Popular terms for people with severe and persistent alcohol/drug problems have for the past two centuries included *drunkard, sot, soaker, hard case, wino, rum-sucker, junkie, dope fiend, speed freak, acid/pot head*, and a wide variety of clinical terms: *oinomaniac, dipsomaniac, inebriate, and narcomaniac*, among the more colorful. I believe that use of the terms *alcoholic* and *addict* and other euphemisms will continue well into the future in alcoholic-alcoholic and addict-addict communications. Such communication reflects the way that stigmatized groups can take a clinical term (or social epithet) and transform it into something positive--positive in terms of facilitating change and positive in terms of intra-group identification.

Members of the New Recovery Advocacy Movement need to discuss whether it is time to drop such objectifying labels in communications to the public in preference for a more respectful and less stigmatizing "people first" language. The terms *alcoholic* and *addict* could be relegated to intragroup communication while being replaced in <u>public</u> communications with the phrase "person/people experiencing an alcohol/drug problem." Such a stance might deflect the arcane arguments over whether someone is or is not this something called an "alcoholic" or "addict" to the much more concrete and verifiable question of whether alcohol and other drugs are creating problems in his or her life.

[7]I am indebted to Ron Roizen for introducing me to this notion.

I believe this shift from labeling someone a thing to describing what a person is experiencing is worthy of serious consideration. The former implies an unchangeable status; the latter a circumstance that can be time-limited and potentially resolvable. People first language emphasizes the person before the disorder. This recommended language also implies that not all problems related to alcohol and other drugs are problems of alcoholism or addiction. It is more respectful and less stigmatizing and it suggests that if a person=s alcohol or drug consumption is creating problems, then he or she should do something about it, regardless of whether the labels alcoholism/alcoholic or addiction/addict apply. It may be time recovering people joined other historically stigmatized groups in rejecting "labeling language" and embracing a "people first" language in their public communications. The challenge will be to find words that are accurate and respectful while still facilitating ease of communication.

Disease / Disease Concept

The proclamation that "alcoholism is a disease"[8] was the foundation of the modern alcoholism movement and became the dominant mantra in the emergence of a modern field of addiction treatment. In the last two decades of the 20th century, debates surrounding the conceptualization of addiction as a disease have reached a crescendo of controversy and professional acrimony.[9] Historical momentum places the "disease concept" at the feet of the New Recovery Advocacy Movement. It is both inevitable and desirable that the potential role and relative value of this idea be thoroughly discussed and debated within the New Recovery Advocacy Movement.

There are at least three potential choices. First, the New Recovery Advocacy Movement could, like the movements that preceded it, make an addiction disease proclamation one of its core ideas. Second, the New Recovery Advocacy Movement could reject this concept as untenable and seek alternative ways to portray alcohol and other drug problems. Third, the New Recovery Advocacy Movement could, like A.A., declare a stance of neutrality in the addiction disease debate. There are several arguments that make the third of these options worthy of consideration.

While many A.A. members speak of alcoholism as a "disease"[10] or in other medical metaphors, they do so not so much as a declaration of A.A. policy or of science but as sense-making ("It explains many things for which we cannot otherwise account.")[11] The contemporary use of such medicalized language does not reflect the heart of A.A.'s view of alcoholism as represented in its basic texts. Ernest Kurtz, author of *Not-God: A History of Alcoholics Anonymous*, challenges the frequent attribution of the disease concept to A.A.

> *On the basic question, the data are clear: Contrary to common opinion, Alcoholics Anonymous neither originated nor promulgated what has come to be called the disease concept of alcoholism. Yet its members did have a large role in spreading and popularizing that understanding.*[12]

---

[8]Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol,* 5(2):354.

[9]White, W. (In Press) Addiction disease concept: Advocates and critics. *Counselor.*

[10] References to "disease" are more likely to reflect the culture of addiction treatment than the culture of A.A.. (See Kurtz, 2000 footnoted below)

[11]*Alcoholics Anonymous*, 1976, p. xxiv

[12]Kurtz, E. (in press) Alcoholics Anonymous and the disease concept of alcoholism. Alcoholism Treatment Quarterly.

When A.A. Cofounder Bill Wilson was asked in 1961 whether alcoholism was a disease, he replied:

> *We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore we did not wish to get in wrong with the medical profession by pronouncing alcoholism a disease entity. Therefore we always called it an illness, or a malady--a far safer term for us to use.*[13]

Wilson's point here is that A.A.'s focus was not on the debate about the nature of alcoholism, but on the affirmation that there was solution to alcoholism. This is a stance worthy of consideration.

The New Recovery Advocacy Movement must be able to embrace people across multiple cultural contexts who develop alcohol and other drug-related problems through varied paths and which unfold in varied patterns. The arms of the New Recovery Advocacy Movement must be wide enough to embrace widely divergent metaphors to understand and resolve AOD problems. What the New Recovery Advocacy Movement brings so uniquely to these problems is an unequivocal message of hope that they can be solved.

It is not up to recovering people to declare whether addiction is or is not a disease: Such matters are not determined by a vote of the afflicted. Whether severe and persistent alcohol and other drug problems constitute a "disease" is a question for medical science and medical practitioners. What recovering people can bring to this problem is LIVING PROOF of: 1) the reality of recovery, 2) the diversity of patterns of recovery, and 3) the variety of methods used to achieve recovery. While all manner of specialists can claim expertise on addiction, recovering people stand alone in terms of their collective knowledge of how recovery can be initiated and sustained.

Those who advocate placing "disease" language at the forefront of the New Recovery Advocacy Movement often claim that THE biological cause of addiction will be soon found and that the New Recovery Advocacy Movement should lay the social groundwork for that discovery. I have long dreamed of this discovery, and yet I have come to think that this very discovery could have unanticipated and profoundly negative consequences as well as great potential benefit. Let me give two examples. First, in the current social climate, the discovery of anything claimed to be THE primary biological factor in addiction (and its accompanying biological markers) could lead to new forms of invasiveness and discrimination relating to everything from occupational opportunities to access to health and life insurance. Second, what might it mean to people already in recovery from AOD problems who were to discover that they did not possess this newly discovered X factor but who have used a disease metaphor to anchor their recoveries? The New Recovery Advocacy Movement would be well advised to base its core ideas not on a narrowly defined depiction of the source or nature of addiction, but on the broad solutions that exist for its resolution.

The New Recovery Advocacy Movement can still take a stance on the important question, "Who shall have cultural ownership of severe and persistent alcohol and other drug problems?" The answer to that question determines whether persons suffering from such problems sit before physicians, psychiatrists, social workers, clergy, or judges. "Disease" language conveys

[13]Quoted in Kurtz, 2000.

placement of AOD problems in the medical and public health arena, but it invites a whole series of technical debates about whether such problems (or which of these problems) are really a "disease". A "health problems" language has the advantage of opening the doors of the health care system for needed services without the accompanying disease debate controversy. Nearly everyone would agree that sustained, excessive AOD use is a serious health problem while many of those same individuals would argue that these problems do not constitute diseases. The New Recovery Advocacy Movement would be well advised to avoid the distractions of the "disease" debate and maintain their focus in one area: recovery solutions!

While the New Recovery Advocacy Movement avoids the technical debates surrounding the disease concept, it can still demand that severe and persistent alcohol and other drug problems be described and discussed using the language of public health and not a military language that, when misapplied to the containment of health problems, contributes to "ex-communicating and stigmatizing the ill".[14] If it chooses to incorporate the proclamation that addiction is a disease in its pronouncements, then it should define the nature of this disease in a manner that is scientifically defensible.[15]

Treatment Works

"Treatment Works" is an example of a phrase whose purpose is noble--countering cultural pessimism about the prospects of long term recovery--but whose effect is potentially disempowering to addicted and recovering people. The slogan implies that interventions *done to* people with AOD problems (as one would surgically remove a malignant tumor) are responsible for freeing their entrapment. It places the locus of responsibility and accountability for recovery not on the individual with an AOD problem but in the hands of the expert professional and the treatment institution. It detracts from the range of recovery tasks that are not in control of the professional and which are the responsibility of the individual and the wider community. The slogan, by exaggerating the power of treatment, fails to acknowledge the role of resources and relationships outside the scope of the treatment institution in the recovery process.

Compare the institutional slogan "Treatment Works" with recovery advocacy group slogans such as "Recovery is a reality" or "Recovery: LIVING PROOF." All convey optimism, but the former places the focus on the professional expert, while the latter two place the focus on the experience of the recovering person. The New Recovery Advocacy Movement is placing the locus of control for recovery within the recovering person and that person's ability to embrace resources within and beyond themselves to support that recovery. Treatment is viewed not as the instrument of recovery but as a potentially helpful, but often insufficient, ingredient in the recovery process.

Stigma

Reducing the stigma associated with addiction/recovery is emerging as a central focus of the New Recovery Advocacy Movement. There is something about this focus that disturbs me, perhaps an inkling that this focus is slightly askew. I worry that the focus on stigma may direct movement resources to narrowly on public opinion as opposed to the broader arenas of public policy and law. While the New Recovery Advocacy Movement will have many facets, it must be

[14]Sontag, S. (1989) *AIDS and Its Metaphors*. New York: Farrar, Straus, and Giroux.

[15]See White, W. (2001) A disease concept for the 21st century. *Counselor,* 2(2):44-52.

as much a rights movement as a movement that simply seeks to change the social acceptance of addicted and recovering people. Our focus on stigma must be focused on the way that stigma is manifested in discriminatory laws, policies and practices.

Perhaps this is a chicken or egg question. When politicians demonize addicts and propose draconian measures for their sequestration and punishment, are these actions an expression of personal belief or Machiavellian political manipulation? When prison guard unions testify against proposals that would divert addicts from prison to community-based treatment, is this action an expression of their collective perception of addicts or an expression of their need for a continued supply of raw materials (consisting mostly of poor young men-of-color) to support their own careers and the prison as an economic institution? When insurance companies promulgate exclusionary policies against recovering people, are these actions an expression of attitudes or economics? The New Recovery Advocacy Movement must, like all social movements, define as concretely as possible what the movement is seeking to change. The fate of such movements often hinges on the accuracy of that definition. In our approach to stigma, we must ask how a condition that had achieved the status of a medical disease is being again defined in terms of immorality. How could this country take generations to cast aside the "immoral model" of addiction only to decades later re-embrace this very notion? There is more afoot here than simply an evolution of public opinion. That complexity must be understood.

Enable

In the addiction treatment/recovery arena, the act of "enabling" has come to mean any intervention that, with the intention of helping the alcoholic/addict, inadvertently results in harm. It is thought that actions that protect the person not yet in recovery from the consequences of his or her drinking/drugging, increase the likelihood of continued addiction. The concept led family members and counselors alike to fear accusations that they were "enabling" or had become "enablers". That fear escalated even further in the late 1980s. At the peak popularity of "codependency", the most basic acts of human kindness toward others were framed not as evidence of compassion but of psychopathology.

While the term *enable* has been useful in distinguishing helpful from harmful styles of support, the use of the term in this way destroyed the original meaning of "enable" (as used in the social work field). That value needs to be rediscovered within the New Recovery Advocacy Movement. The field of social work has long used the term "enable" to convey a particular type of helping relationship in which the empathy, emotional authenticity, and encouragement of the helper empowered those being helped to do things for themselves that they had been unable to achieve by themselves. Perhaps it is time to rehabilitate the word "enable" (or select an alternative word such as *empower* which, while overused, comes close to the desired meaning) that can help us recapture the vibrancy and usefulness of the original meaning of this concept.

Relapse

I'm not sure about the word relapse. Something in the emotional baggage of the word troubles me. In the research world, the word is plagued by innumerable definitions that range from any use of alcohol or substitute drugs to a return of alcohol and other drug-related problems, the latter implying that relapse arrives not with drinking but with its consequences. Some within the New Recovery Advocacy Movement are pressing to replace references to "relapse" with the term "reoccurrence" on the grounds that the latter more closely parallels the language used with

other chronic diseases and is less morally judging than the term relapse. This is one we need to include in our audit of language in the New Recovery Advocacy Movement.

Recovering/Recovered

Consensus on how to refer to people that were once addicted but are no longer addicted has never been reached. Such people have been referred to as *redeemed (or repentant) drunkard, reformed drunkard, dry drunkard, dry (former) alcoholic, arrested alcoholic, sobriate, ex-addict, ex-alcoholic* (the latter being the only word removed from the first edition of the book Alcoholics Anonymous[16]). They have been described as *sober, on the wagon, drug-free, clean, straight, abstinent*, *cured, recovered*, and *recovering*. 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 of for a permanent resolution of addiction.[17] James Royce criticized the use of "recovering" in 1986 on the grounds that the term implied that the alcoholic was still sick years after he or she had stopped drinking.[18] He believed "recovering" should be used to designate only the earliest stages of alcoholism remission. 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."[19]

I think this is another area in which one language could be used inside recovery circles while another language could be used to speak publicly. The terms "seeking recovery," "in recovery" and "recovering" could continue to be used to depict individuals who are making concerted efforts to remove destructive patterns of alcohol and other drug use from their lives. This usage would be congruent with how we speak of people responding to other chronic conditions and illnesses. The language assumes both commitment and progress rather than a complete absence of symptoms. In a similar manner, the term "recovered" could be used to depict those who have achieved an extended period of symptom remission. The period used to designate people recovered from other chronic disorders is usually five years without active symptoms.

Arthur Frank, noting the propensity to call those who have lived through life-threatening illnesses "survivors", casts his vote for the term "witnesses"--the latter suggesting the responsibility to tell others what happened.[20] Perhaps there is a day in the future when, with

---

[16]Kurtz, E. (1999). *The Collected Ernie Kurtz*. Wheeling, WV: The Bishop of Books..

[17]Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In: *The Biology of Alcoholism, Vol. 5, Treatment and Rehabilitation of the Chronic Alcoholic,* Ch. 12, p 546, Eds. Kissin, B. and Beglieter, H. New York: Plenum Press.

[18]Royce, J. (1986). Recovered vs. recovering: What=s the difference? *The U.S. Journal* March, p.7.

[19] Harrison, D. (1860). *A Voice From the Washingtonian Home.* Boston: Redding & Company.

[20]Arthur Frank (1995). *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press.

diminished stigma, all recovering and recovered people will have the choice to be *recovery witness*. What would be the impact upon this country if it were to experience thousands of voices of recovering people, with the influence of each witness spreading outward like the spreading ripples of a rock thrown into water?

Anonymity and Passing

Few issues have been as contentious in the early history of the New Recovery Advocacy Movement as the meaning of anonymity. Many recovering individuals in Twelve Step groups were offended by invitations to step forward to "put a face on recovery" on the grounds that such declaration would violate the traditions of A.A., N.A. or other Twelve Step Groups. Historically, anonymity served three functions in A.A.: 1) It protected individuals from the harm that can ensue from a stigmatized condition, 2) it protected the fellowship of Alcoholics Anonymous from the potentially discrediting behavior of its members, and 3) it served as a spiritual exercise--an antidote to narcissism and grandiosity. These functions were so important that anonymity was codified in A.A.'s Twelve Traditions. I have argued elsewhere that the traditions of Alcoholics Anonymous are the primary reason that A.A. survived when all of its predecessors self-destructed.[21] Given this, any potential compromise of that source of resiliency should be closely examined. There are three of the Twelve Traditions that have particular relevance to the New Recovery Advocacy Movement.

Tradition Six states: "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".[22] A.A./N.A.'s name should thus not be drawn into any aspect of the New Recovery Advocacy Movement. No A.A./N.A. group or no A.A./N.A. member should be asked to participate in or support any recovery advocacy organization as a group or individual representing A.A./N.A..

Tradition Ten states: "Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy".[23] Recovery advocacy, by definition, involves itself in public policy issues, some of which involve those very controversies. That means that the name of A.A./N.A. should never be brought into those advocacy efforts.

Tradition Eleven states: "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".[24] This means that no one in the New Recovery Advocacy Movement who is a member of A.A./N.A. should reveal that affiliation "<u>at the level of press, radio and films".</u> That does not mean that persons in A.A./N.A. cannot publicly identify themselves as a persons who have recovered or are recovering from alcoholism/addiction (as long as no A.A./N.A. affiliation is noted at the media level.)

Keeping one's recovery status silent at ALL levels is not respectful of recovery fellowship traditions. (It may even violate the Tradition Five which states: "Each group has but one primary purpose--to carry its message to the alcoholic who still suffers".) Silence at all levels is not anonymity but what sociologists call "passing"--hiding one's stigmatized status by failing to

[21]White, W. (2001). Pre-A.A. Alcoholic Mutual Aid Societies. *Alcoholism Treatment Quarterly*. In Press.
[22]*Twelve Steps and Twelve Traditions* (1981). NY: Alcoholics Anonymous World Service, Inc.
[23]Ibid.
[24]Ibid

disclose one's link to a stigmatized condition or group and, in effect, passing as "normal"[25] (or what some people in recovery refer to as a "civilian"). Erving Goffman, in arguably the most famous essay on stigma ever written, noted the toll stigma takes on the stigmatized. He reported how the autobiographies of such people often describe finally reaching a "state of grace" where they no longer felt a need to pass and were able to accept themselves as whole persons.[26]

Senator Harold Hughes, two years before he died, spoke out on the effect "passing" had on others.

> *We in recovery have been part of the problem. We have both accepted and perpetuated the stigma that kept us from getting help and that has killed millions of addiction disease victims. By hiding our recovery, we have sustained the most harmful myth about addiction disease: that it is hopeless. And without the examples of recovering people, it's easy for the public to continue thinking that victims of addiction disease are moral degenerates--and that those who recover are the morally enlightened exceptions. We are the lucky ones--the ones who got well. And it is our responsibility to change the terms of the debate, for the sake of those who still suffer*[27].

The New Recovery Advocacy Movement is calling people to respect the recovery fellowship tradition of anonymity, but to carefully consider the costs of "passing" (refusing to acknowledge, not their AA affiliation but, their recovery status) on their own emotional health and its effect on those still suffering from alcohol and other drug problems. The New Recovery Advocacy Movement is declaring that it is time for a vanguard of recovering people to stand up and announce their presence in this culture--NOT as members of any identified recovery fellowship, but as members of a larger recovery community. This invitation explicitly includes family members in recovery. Even those of us who have lost loved ones to addiction must become more than saddened spectators of such loss. We must find a way to tell our lost person's story wrapped within our own story. We must witness for them as well as ourselves.

New Recovery (Advocacy) Movement

When grass roots recovery advocacy organizations began to appear, it was only natural to refer to these groups collectively as the "New Recovery Advocacy Movement". If these local groups do flower into a sustainable movement, the day will come when they will need to consider how to refer to their collective efforts. For now, the "New Recovery Advocacy Movement" designation can be used (but should be kept on probation) until it is either blessed by these local groups or until a better term comes along. To avoid confusion, references to the "New Recovery Advocacy Movement" would best be accompanied by the stipulation that what makes this movement "new" is its shift in focus from mutual aid to a focus on creating pro-recovery community attitudes and policies and on expanding the range and quality of local recovery support resources. Participants in the New Recovery Advocacy Movement are not there for personal change for themselves or others: most have other venues where such personal work

---

[25]Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster, Inc.

[26]Ibid, p. 102.

[27]Hughes, H. (1994-1995) Coming out of the Closet to Fight Abuse. SOAR USA Bulletin Fall/Winter. Posted at **http://www.aaw.com/library/soar1.html**

is done. Clarifying that the locus of intervention for this movement is not the individual but the community may help distinguish it from other recovery-related organizations, e.g., mutual aid groups, treatment agencies. In contrast to both treatment and mutual aid, the focus on the New Recovery Advocacy Movement is on the ecology of recovery. It calls upon recovering people to move beyond their personal service work and become recovery activists.

Words/Concepts We Need to Elevate and Celebrate

We've only just begun to fashion a vocabulary to deal with the "silences" of our lives. --Toni Cade Bambara

The New Recovery Advocacy Movement will need to develop a core lexicon that distinguishes itself both from mutual aid societies, from professionally directed addiction treatment and from earlier addiction-related advocacy movements. Some of the following words and phrases are worthy of nomination to a visible status in that lexicon: recovery, recovery community (or communities of recovery), advocacy, sustainability, recovery support services, recovery coach, recovery pathways/styles, Presenting the Faces and Voices of Recovery / Living Proof, recovery friends.

Recovery

If there is a word and concept that should be at the center of the New Recovery Advocacy Movement, it is unquestionably that of *recovery*. Embracing this concept is more important and a more difficult process than might be initially thought.

Elevating the concept of recovery is important because it reflects a shift from a pathology paradigm to a resiliency paradigm. It is a way of declaring that it is time for "addiction treatment" agencies to become "recovery agencies". This means that treatment agencies need to shed their models of acute intervention in which severe and persistent alcohol and other drug problems are treated as if they were a broken arm or a bacterial infection. It is time the focus shifted from brief episodes of acute intervention to models that reflect an understanding of, and focus upon, the long-term recovery process. The problem right now is not just that treatment resources are declining; it is that the number of treatment episodes far exceeds the number of people entering long-term recovery.

As the leaders of this New Recovery Advocacy Movement interface with policy and treatment specialists, they will be tempted to be pacified with superficial changes in rhetoric, token representation, and a few minuscule grants or specialty positions. The goal of the New Recovery Advocacy Movement as it relates to the field of professionally-directed treatment is nothing short of radical changes in:

- the goals to which those services are directed;
- how, when and by whom those services are delivered and evaluated; and
- the settings in which such services are delivered.

It is incredible when one thinks about it that the word *recovery* does not appear in any of the major arenas of the field's activities (e.g., prevention, early intervention, treatment) nor in the names of the field's major governmental and professional organizations.(What, for example, would be the implications of changing the name of the Center for Substance Abuse Treatment

to the Center for Addiction Recovery?) What the New Recovery Advocacy Movement is saying is that the time for a major and sustained focus on RECOVERY is long overdue.

Having now made the case for elevating recovery as a word and concept, it is important to acknowledge a few of the challenges that lie ahead. The most nettlesome may be that of defining the precise meaning and boundaries of the concept of recovery.

There are several options available. First, the New Recovery Advocacy Movement could limit the use of this term to the resolution of severe and persistent alcohol and other drug problems. But even here we must struggle to define what we mean by "resolution." The resolution of chronic problems, and particularly chronic diseases, often demonstrate a high degree of variability of outcome that include both full and partial recoveries. Achieving consensus on the meaning of full remission, defined by Milam and Ketcham as "a return to normal functioning based on total continuous abstinence from alcohol and substitute drugs",[28] could itself be troublesome for some if, for example, nicotine were to be included in the category of substitute drugs. Such a definition would deprive a lot of "old-timers" of their recovery status and tenure. Particularly difficult will be the question of whether recovery ought to be defined in terms of optimal global functioning--a measure that could include a movement from problematic to non-problematic drug use by some individuals. Our stance on this question will be determined, in part, by whether the term recovery will be applied to the resolution of the whole spectrum of alcohol and other drug related problems or to the more narrowly defined clinical categories of drug addiction/dependence. If our choice is the former, then we will need to carefully define what we mean by "problem" and "resolution".

A second option is for the New Recovery Advocacy Movement to apply the term recovery to the sustained absence of severe and persistent compulsive behavior (other than that involved in the clinical entity, obsessive compulsive disorder). This would expand the New Recovery Advocacy Movement into the arenas of what have come to be called "process addictions" (toxic relationships with food, work, sex, money, etc.) An even more encompassing definition would include all people who have survived a life-threatening disorder or condition--a definition that would dramatically expand the boundaries of the New Recovery Advocacy Movement.

Defining the boundaries of "recovery" is not an inconsequential process. Not only is this boundary important, but the timing of this boundary and how it evolves over time is also important. To start with, too broad a definition or the too rapid expansion of that definition could mortally wound this movement via loss of mission and dissolution. It may be important to maintain the identity of this New Recovery Advocacy Movement in terms of recovery from chemical additions at the same time the organizations and members of the New Recovery Advocacy Movement will need to be open to project-specific collaborations with parallel movements. Perhaps most important is that such definitions and evolutions come from inside the movement rather from external ideological, institutional or financial influences. Eventually, the New Recovery Advocacy Movement will need to link itself to a larger body of people recovering from life-depleting and life-threatening illnesses and conditions.

In that same spirit of linking and expanding, the line between active addiction and recovery may, in the end, need to be understood as not a line (as I all too often am prone to

[28]Milam, J. and Ketcham, K. (1989). *Under the Influence: A Guide to the Myths and Realities of Alcoholism*. New York: Bantam Books.

portray it) but a very long process. One of the reviewers of an early draft of this paper eloquently detailed this broader perspective:

> *...our working definition of recovery is the choice of life over death. Anything that manifests the will to live can be defined as recovery in this scheme...Active alcohol and drug use was for me a way out of pain--an alternative to suicide...For me, addiction was probably the only answer...It was my way of saying yes to life over death. It was in itself a way of grasping for recovery. In this way, addiction and recovery are not separated by a hard and fast line, but constitute a continuum...Acknowledging this helps to unite those who need recovery with those who are in recovery (as you define it in the article).*

The above comments offer much food for thought as this new movement tries to articulate the need for a continuum of local recovery support services. By raising the possibility that recovery begins with experiences during active addiction,[29] new types of interventions may be developed through which people may enter conscious, active recovery at earlier and earlier stages of change.

Recovery Community/Communities of Recovery

In an earlier paper, I defined the "recovery community" as "a voluntary association of those impacted by AOD problems who come together for mutual support and joint action on AOD-related issues". The members of this community include those in personal recovery from addiction, family members impacted by AOD problems, professionals whose identification with this community transcends their paychecks, and other people of good will concerned about AOD problems. What binds this community together is their history of shared experience and their willingness to move beyond mutual fellowship to social and political advocacy on recovery-related issues. Yet using "community" in the singular implies something of a homogenous group of people and shared interests. A "recovery community" exists only to the extent that multiple and diverse recovery communities reach beyond their own geographical and cultural boundaries to embrace such an identity. Ernest Kurtz has suggested that the phrase "communities of recovery" may more precisely describe the actual nature of the recovery advocacy constituencies.[30] I think this suggestion is one worthy of consideration. Reminding ourselves that we are many communities bound together only by shared experience and a shared vision may counter efforts to foist an overly centralized and hierarchical structure upon this evolving movement.

Advocacy

The second word/concept (other than recovery) most central to the New Recovery Advocacy Movement is *advocacy*. That word and function must be kept to the forefront or this movement could suffer the fate of its predecessors. The advocacy function of many local mid-20th century alcoholism councils was lost as such groups evolved into the boards of treatment agencies during the flood of new federal and state monies. Every publication regarding the New

[29]This notion is completely congruent with the growing body of" stages of change" research and empirically-based "developmental models of recovery."

[30]Personal Communication, December, 2000.

Recovery Advocacy Movement should begin with a declaration/reminder of what recovery advocacy is and is not.

Advocacy is about changing the cultural perception and attitudes that underlie ill-conceived policies and practices directed toward addicted and recovering people. Advocacy is about confronting the political, economic and institutional interests that benefit from such policies and practices. Advocacy is about conveying alternative perceptions and beliefs and generating the influence to change ineffective and harmful policies and practices. Advocacy is about turning personal stories into social action; it is about turning recovery outwards. Advocacy is about acquiring and using power to change the ecology of addiction and recovery. If the New Recovery Advocacy Movement is truly an advocacy movement, then it will be at its heart a movement about the expansion of recovery resources in communities across the country.

There are two things advocacy is NOT. First, advocacy is not mutual aid. If recovery advocacy organizations are mistakenly thought to be mutual aid societies, both the organizations and their members are at risk of harm. Participation in the New Recovery Advocacy Movement is founded on the primacy of personal recovery, but involvement in this movement must be focused on recovery ADVOCACY, not mutual aid. Advocacy is not a personal recovery program! (The history of recovery advocacy is strewn with the bodies of those who believed advocacy work would by itself keep them sober.)

Second, advocacy is not about entering into competition with mutual aid groups or treatment agencies in the provision of direct services to those seeking recovery. Advocacy is about environmental change--changes in cultural perceptions and beliefs, changes in social policies, changes in laws, and changes in institutional practices. New Recovery Advocacy Movement organizations must keep their eyes on the primacy of this advocacy function. Their primary responsibility is to advocate for and help organize and support needed treatment and recovery support services, not to operate/deliver those services. When community organizers take on such operational functions, their viability as organizers is usually lost. Some New Recovery Advocacy Movement organizations have and will continue to involve themselves in recovery support services, but great care must be taken to assure that these service functions do not devour the advocacy agenda. If advocacy gets pushed into the shadows and lost to the demands of direct service, the New Recovery Advocacy Movement will be absorbed into America's ever-growing system of health and human services and die. The purpose of advocacy is to influence that system, to hold that system accountable for its practices and the stewardship of its resources, and to help organize indigenous resources that transcend that system.

As important as this concept it, use of the word advocacy does come with its own problems. Several local recovery advocacy organizations have been denied their status as a 501C3 agency because of use of the word advocacy in their application. Because advocacy is often interpreted exclusively in terms of lobbying, emphasis upon this function may deny some organizations their tax-exempt status. While terms like "public education" and "policy education" may help avoid such difficulty, this dilemma provides an example of how the quest for financial resources begins to suddenly or incrementally alter the very essence of how a movement defines itself.

Sustainability

The success of the New Recovery Advocacy Movement requires not only unwavering focus on recovery advocacy, but a way to sustain this work over an extended period of time. The word/concept of sustainability will need to remain at the center of consciousness of New Recovery Advocacy Movement organizations. Such sustainability will require: 1) procuring financial resources to support the minimal level of infrastructure required to sustain New Recovery Advocacy Movement activities, 2) recruiting and developing local New Recovery Advocacy Movement leaders, and 3) developing local membership cadres committed to the enduring work of the this Movement.

An Important Debate: Before discussing the financial sustainability of recovery advocacy organizations, it is important to first ask what kind of financial resources such organizations require. The answers will vary in what will be a lively and important debate on this question, and these variations will come out of both differences in philosophy and differences in community and cultural contexts. The question is a crucial one. The fate of recovery advocacy organizations can be doomed by too little money, too much money, ill-timed money, poisoned (mission-corrupting) money, and dependence upon money from a single source. My own bias is towards a minimalist approach to infrastructure for this movement. The success of this movement will be measured not by the size of the budgets of its organizational members but by the degree of changes in community attitudes and increases in recovery resources that they are able to generate in local communities. It is my hope that the core of this movement must remain focused on the power of voluntary service. It is very important that paid positions not further undermine the service ethic of local recovering communities.

Financial Sustainability: Many New Recovery Advocacy Movement organizations will be seeded with membership contributions, funds from philanthropic foundations, or from federal, state, or local agencies concerned with alcohol and other drug-related problems. While these funds can be supplemented by a wide variety of fund-raising activities, it is a rare organization that will be able to fully sustain both its infrastructure and its core advocacy work in the larger community without a stable stream of funding, no matter how small that funding may be.

Federal, state, and local funding agencies provide continued support for prevention and treatment services but expect the functions of advocacy and community resource development to be self-sustaining after a year or two of seed money. This policy is fundamentally flawed in both design and execution. The design flaw is in refusing to fund the very functions that can enhance treatment outcomes while continuing to fund serial episodes of acute treatment that often fail because of the barriers to, and lack of resources to support, recovery in the natural community environment following discharge from treatment. The execution flaw is that advocacy organizations are forced to transform themselves into service organizations in order to financially survive. Ironically, these organizations then suffer poor service outcomes because of the lack of the very resources for which they were originally advocating.

It is time that the functions of recovery advocacy and community recovery resource development were recognized as being on par with prevention and treatment and were

provided at least modest streams of funding to sustain them over time.[31] Pouring money into treatment that initiates recovery without the indigenous community supports to sustain those recoveries represents extremely poor stewardship of funding resources. It is not enough to create temporary sanctuaries in which people can initiate brief experiments in sobriety; that physical and psychological sanctuary must be extended into the wider community where the most fragile, treatment-initiated sobrieties will either be devoured or nurtured into maturity. It makes no sense to provide ongoing financial resources to support recovery initiation while providing no ongoing financial resources to support recovery stabilization and maintenance. This is analogous to providing half the dose of antibiotics required to fully suppress an infection or conducting heart bypass surgery with no prescriptions and support for managing such post-hospitalization behavioral risk factors as diet, exercise and contraindicated drug use.

Rectifying this situation will require that funding agencies find ways to shift from a treatment paradigm to a recovery paradigm. Recovery services (recovery advocacy, recovery resource development, and recovery support services) need to be financially supported on a continuing basis on par with prevention and treatment. Professional treatment needs to be seen again in proper perspective as one potentially helpful, but not always necessary or by itself sufficient, step in the larger and more enduring process of recovery.

Leadership Sustainability: The New Recovery Advocacy Movement in the opening of 2001 represents a unique phenomenon in that it is a movement spreading with no national leadership or centralized national structure. The grassroots quality of the New Recovery Advocacy Movement is at this moment one of its greatest strengths. A time will come when national leaders will be needed (at least individuals who can act in this role on an ad hoc basis), but these should be drawn from those who have been seasoned in local leadership roles. Local leaders have assumed these roles through a combination of being called, being chosen (by the local recovery community) or just plain happenstance. The New Recovery Advocacy Movement will need to develop a vision and a strategy for how its future leaders will be recruited, developed, and supported over time.

Cadre Sustainability: The impact of the New Recovery Advocacy Movement will not be determined by the size of its formal membership. In contrast to mutual aid groups whose influence is measured by the number of individual members, 100 local recovery advocacy organizations each with a small core of committed members could change how this country perceives and responds to those with severe and persistent alcohol and other drug problems. The challenge will be to develop these local cadres of committed individuals and to manage the health of such cadres over an extended period of time. Such sustainability will require strategies of mutual support, not for recovery (that must come from other sources such as mutual aid groups), but for the emotional wear and tear inherent in advocacy work.

[31]There are actually historical precedents for such funding that span NIAAA funding of NCA to organize state and local advocacy organizations to CSAT=s current Recovery Community Support Program.

The primacy of sustainability is to the New Recovery Advocacy Movement organization what the primacy of recovery is to the New Recovery Advocacy Movement member. Recovery advocacy, like recovery itself, is an enduring marathon, not a sprint.

Recovery Support Services / Recovery Coach

Professionally-directed treatment rose in the mid-20th century as an adjunct to the recovery process, but as the treatment field grew to enormous proportions, it tended to define recovery as an adjunct to itself. Getting treatment was important; on-going recovery management was relegated to the status of an afterthought called "aftercare," or more recently "continuing care." This imbalance can be corrected by integrating treatment within a larger umbrella of recovery support services.

Recovery support services are actions designed to:

1. eliminate personal and environmental obstacles to recovery (including obstacles to participation in pro-recovery activities)
2. elicit positive motivation for personal change in persons experiencing alcohol and other drug-related problems,
3. link those wishing to recovery to both professional and indigenous community recovery resources, and
4. sustain a supportive, cheerleading, problem-solving relationship with persons in pre-recovery and early recovery, with a particular emphasis on guiding the individual through the pre-action stages of change and helping solidify the maintenance stage of change.

Who will provide these new recovery support services that now either don't exist or are scattered piecemeal across the roles of counselor, counselor aides, detox technicians, case managers, outreach workers or volunteers? Actually this function once existed, but disappeared when the role of addiction counselor was professionalized. The focus of the earliest roles I filled within alcoholism programs of the 1960s and early 1970s was not on counseling or psychotherapy, but on developing and mobilizing indigenous recovery resource on behalf of individuals seeking help for alcohol and other drug problems. My experience was not unique. J. David Else has described the way in which he was indoctrinated at the Gateway Rehabilitation Center in 1970:

> *Your job is not to cure or fix people. Healing is our goal and healing comes from the community. Your role is to build and enhance the community here*.[32]

When the role of the modern alcoholism counselor was first formulated, the focus of the role was not therapy. Robert Wayner, one of the founding members of the National Association of Alcoholism Counselors and Trainers explains:

> *Our original idea was to have counselors train people in communities to deal with the growing alcoholism problem. The training we taught was not based on clinical skills; it was based on a community development model...*[33]

[32]Else, J.D. (1999). Recovering Recovery. *Journal of Ministry in Addiction & Recovery,* 6(2):11-23.

[33]NAADAC: 20 Years of Leadership. (1992). *The Counselor,*10(3):15-27.

In the rush to professionalize, the focus shifted from resources and relationships in the alcoholic's natural environment that could help initiate and sustain recovery to the alcoholic's cells, thoughts and feelings. The dominant influence shifted from the discipline of community development to the discipline of psychotherapy.[34] The New Recovery Advocacy Movement seeks a shift in focus from the unique pathology of the addicted individual to the social ecology of addiction and addiction recovery.

While recovery support functions could be integrated into many roles within the addiction treatment "continuum of care," it may be easiest to simply create the new role of *recovery coaches* (or what some are calling *recovery guides* or *recovery support specialists*) and integrate these specialists into the many service settings in which alcoholics and addicts are encountered. The focus of the recovery coach role must be one of tapping the service ethic of the indigenous community--not on replacing that ethic with paid service activity. The focus must be on recovery resource development and linkage rather than on traditionally delivered direct service.

There will be many questions to address in the formulation and implementation of this new role.

- How shall this role be defined and delineated from existing services roles?
- How will this role be effectively integrated into a larger interdisciplinary service delivery team?
- What qualifications and competencies will be required to fill this role?
- How will "folk (experienced, firsthand, internal) knowledge" be valued in comparison to "formal (acquired, secondhand, external) knowledge." How should the financial compensation of the recovery coach compare to other service roles? Will the level of compensation allow us to recruit and retain the best recovery coaches?
- What standards of ethical conduct and boundary management should guide the relationship between the recovery coach and those they support?

All of these questions require serious and sustained discussion within the New Recovery Advocacy Movement and the larger addiction/recovery service arena. It will be important for the New Recovery Advocacy Movement to keep these positions/functions from being overly professionalized. The goal is not to speed the professionalization of this role, but to actually slow such processes and maintain the role's dynamic quality.

There is a danger that accompanies the growing recognition of the need for recovery support services. If the treatment field does not find a way to develop adequate recovery support services, these services may emerge as a separate system developed out of recovery advocacy organizations. The danger here is a separation between recovery support services and treatment services similar to the split that has long existed between the treatment and prevention fields.[35] That split would not benefit the people both treatment and recovery advocacy

[34]For an elaboration of this discussion, see White, W. (2002). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly* 19(4):1-32.

[35]I would like to acknowledge Don Malec of Recovery Communities United in Chicago for first asking me to think about this potential danger.

organizations are pledged to serve and could result in recovery advocacy organizations competing with treatment agencies for a shrinking pool of funding.

Recovery-oriented Systems of Care

- One function of the New Recovery Advocacy Movement will be to influence professionally-directed addiction treatment toward a more recovery-oriented system of care. Briefly, this will entail such changes as:

- the Integration of medical/psychotherapy model of treatment with community development models of recovery
- an aggressive approach to eliminating personal and environmental obstacles to recovery ("recovery priming")
- the reconceptualization of treatment from that of the first line of response to addiction to a last resort--a safety net for those requiring resources beyond indigenous recovery support systems, e.g., family and extended family, the church, mutual aid groups
- a shift from time-limited acute interventions to long-term recovery management--a shift from treatment planning to recovery planning[36] --and the abandonment of such concepts as *discharge* and *aftercare*
- a shift in locus of service delivery from the treatment institution to the natural environment of the client, and
- a shift from a hierarchical (expert-patient) helping model to a partnership (sustained recovery management) model.[37]

Recovery Pathways/Style

Anatole Broyard once observed that "every seriously ill person needs to develop a style for their illness",[38] and I would add, "a style for their recovery." If we carefully listen to the stories of recovered and recovering people, we will find a staggering diversity of such styles of addiction and recovery. We have yet to coin the words to depict such variations. If we are truly serious about recognizing and celebrating the growing pluralism of the culture of recovery, then we need to evolve a language that depicts such diversity. One area of substantial variation involves whether (and the degree to which) addiction and recovery are pursued as solo or shared experiences. I have earlier described acultural (addiction isolated from other addicts), bicultural (dual membership in the culture of addiction and the larger society) and culturally enmeshed (a life consumed by and within the culture of addiction) styles of addiction and counterpart styles of recovery.[39] But a simpler language is needed to describe such variations. Here are some possibilities.

1. *Affiliated recovery* is a phrase that depicts the traditional pathway of initiating and sustaining recovery within an organized recovery mutual aid society. Affiliated recovery would include those individuals who are recovering within the framework of AA/NA or in such 12-step

[36]See Borkman, T. (1997. Is recovery planning any different from treatment planning. *Journal of Substance Abuse Treatment,*15(1):37-42.

[37]See Eisler, R. (1987). *The Chalice and the Blade*. San Francisco: Harper Collins Publishers.

[38]Broyard, A. (1992). *Intoxicated by My Illness.* New York: Fawcett Columbine

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

alternatives as Secular Organization for Sobriety or LifeRing. The term would also apply to those individuals who are recovering via participation either in specialized addiction ministries or broader religious pathways of recovery in which addiction is framed as a sin and recovery is defined in terms of redemption and living within a sober, faith-based community.

2. *Virtual recovery* or *cyber-recovery* is a phrase that describes people who have initiated or sustained their recovery from addiction through internet discussion and support groups, without face-to-face contact with other people in recovery.

3. *Disengaged recovery* is a term that depicts people who initiated their recovery within a professionalized treatment context or a recovery mutual aid group, perhaps even sustained that recovery for an extended period of time within that professional or mutual aid structure, but then disengaged from active participation while continuing to maintain their sobriety and emotional health through other methods. Such eventual disengagement is anticipated and encouraged in some groups (e.g., Women for Sobriety). It also occurs in traditional Twelve Step recovery groups much more frequently than publicly acknowledged, but this style of recovery has not been "blessed" by the Twelve Step community.[40]

4. *Solo recovery* is a term that describes people who recover from severe alcohol and other drug problems without the aid of either professionally-directed treatment or participation in recovery support groups. Terms such as *maturing out, natural recovery, spontaneous remission, auto-remission*, and *untreated recovery* have been used in the addiction research community to depict this phenomenon. The acknowledgment of solo recovery is an important step in celebrating the growing pluralism of the culture of recovery in the United States, but it is likely that this term will give way to other yet to be coined terms. The reason is that studies of natural recovery confirm that most people who recovery from addiction without the aid of treatment or support groups do so with significant family and social support for their personal recovery. One of the challenges of involving people in solo recovery in the New Recovery Advocacy Movement is that many such individuals shed alcohol and other drug problems without incorporating addiction or recovery into their personal identity and story. It will require visible accounts of solo recovery for such individuals to self-identify themselves and consider participation in this movement.

5. *Manual-guided recovery* is a term reflecting a mid-point between affiliated and solo recovery. Here the individual seeks outside assistance in the form of a written manual that provides a highly proceduralized approach to altering his or her relationship with alcohol and other drugs without face-to-face contact with others in recovery. As more of these manuals move on to the Internet, the paths of virtual recovery and manual-guided recovery are likely to merge.

---

[40]Given that open acknowledgment of this phenomenon is likely to stir controversy and powerful resistance in some circles, I will briefly elaborate. I believe that sustained participation in mutual aid groups is an essential sobriety maintenance function for many people, that such sustained participation is a framework for spiritual fulfillment and meaningful social fellowship for many people, and that the survival of mutual aid groups as viable organizations requires a cadre of leaders and elders committed to sustained involvement. This does not alter the fact that many people with severe and persistent alcohol and other drug problems can and do achieve sustained recovery without life-long participation in such groups. This is also a way of stating my belief that the impact of AA and NA on America=s alcohol- and other drug-related problems far exceeds the impact reflected in the number of active members at any point in time.

There may be better words to depict the unspoken realities and diversities of these recovery pathways. As the diversity of recovery paths becomes more fully charted and culturally known, we will evolve new terms to depict this diversity at the same time the need for such designation will likely diminish. Once charted and known, what will become increasingly important to the New Recovery Advocacy Movement is that people ARE in recovery, not how that recovery was achieved or is being sustained.

Presenting the Faces and Voices of Recovery / Living Proof

It is only when we reach a critical mass of people in America who personally know someone in stable recovery that attitudes toward addiction and the possibility of recovery will change. This is how attitudes toward a number of illnesses changed. The death sentence connotations of cancer, for example, changed only when known survivors of cancer reached a point of critical mass in the culture. The problem with addiction recovery is this: Most people already know someone in stable recovery from addiction but they don't know of this individual's recovery status because it has been withheld. It is when that status becomes known that people have to confront their own stereotypes about addiction and recovery. That's why "coming out" or "going public" (declaring one's stigmatized identity) is a political act. What the New Recovery Advocacy Movement is advocating is "reverse passing" -- the creation of a cadre of people declaring their recovery status who could continue to "pass" if they chose to. One wonders what it would mean to those actively addicted and to the citizens of this country to witness people in incomprehensible numbers marching in Washington to proclaim their stable and enduring recovery from addiction.

The strategy of "Putting a Face on Recovery" and offering "Living Proof" is a sound one, but the question is how do we launch and sustain this campaign without doing harm to those at the forefront of this campaign? That harm is real and can come in the form of social, political, and financial discrimination. Given such potential harm, it is best to launch this campaign in phases, beginning with those who face the least harm to those who face potentially greater harm. This way, the success of the early campaign can serve to lessen the harm to those whose disclosures follow in the months and years after this first wave. The New Recovery Advocacy Movement does not need, is not asking, nor would desire, that all recovering people disclose their recovery status. What is needed is a vanguard of recovering people from all walks of life to challenge the stereotypes about addiction and recovery and to challenge the most objective forms of prejudice and discrimination. This vanguard will be to the New Recovery Advocacy Movement what the Freedom Riders were to the Civil Rights Movement.

In calling for such a vanguard, we should be fully cognizant of the price members of this vanguard may pay for their disclosure and build in supports to counter such effects. Erving Goffman in his classic work, *Stigma*, notes the potential price of forsaking anonymity:

> *The problems associated with militancy are well known. When the ultimate political objective is to remove stigma from differentness, the individual may find that his very efforts can politicize his own life, rendering it even more different from the normal life initially denied him--even though the next generation of his fellows may greatly profit from his efforts by being more accepted*.[41]

[41]Goffman, I. (1963). *Stigma: Notes on the Management of a Spoiled Identity*. New York: Simon and Schuster, p. 114.

We do not want the recovery community to become a community of pariahs who, once identified, face greater social sequestration and discrimination. We need to identify the exact ways in which recovering people could be harmed by "coming out"[42] and communicate those risks to those inside the New Recovery Advocacy Movement at the same time we seek to alter those very conditions. By phasing the process of "going public" from those with least to those with greater risks in disclosing, it might be possible to reduce and manage such harm. The New Recovery Advocacy Movement can recruit this vanguard while fully respecting the timing of participation in this effort as well as the decision to withhold public disclosure of recovery where to do so would by injurious to individuals or their families. There is much we could learn on this issue by studying the history of the gay, lesbian, bi-sexual and transgender rights movement.

New Recovery Advocacy Movement organizations might consider altering the phrase "Putting a face on recovery" to "Presenting the faces and voices of recovery." This shift emphasizes two things. First, there needs to be many faces put on recovery to convey the growing size of communities of recovery, and there needs to be many faces to reduce the individual vulnerability of going public. This vulnerability stems both from social/occupational/economic injury that could accompany disclosure and the challenge to, in the words of Bill Wilson, "keep those fool egos of ours from running hog wild..."[43] The vulnerability of a recovering person is magnified when they stand alone under a media spotlight; the strength of recovering people is enhanced when they stand together in such numbers that no spotlight can focus on one face or fully encircle them. This might be called the power of the plural that has long marked addiction recovery: the discovery that what cannot be achieved alone can be achieved together.

Story

If there is anything at the heart of the recovery process it is surely the processes of story reconstruction and storytelling. Arthur Frank has eloquently detailed the way in which "seriously ill people need to become storytellers in order to recover the voices that illness and its treatment often take away".[44] Many recovering people experience a need to "reclaim their voice" because that voice was culturally suppressed or abdicated. Those addicted and those recovering from addiction have had multitudes of professional specialties and social and religious reformers speaking about them and on their behalf, but rarely have their first-person voices been heard without the filter of professional/moral interpretation. The New Recovery Advocacy Movement is in part a declaration that recovering people should be speaking for themselves--should be playing a part in shaping the knowledge base of addiction medicine and addiction counseling as well as having a role in shaping social policies that affect the lives of addicted and recovering people. It is in the transition from personal recovery to social/political advocacy that recovering people discover the "connection between telling their stories and changing the world".[45]

---

[42]Such injury could include job discrimination related to hiring, advancement, discharge particularly in positions calling for either high moral character (clergy, teachers, political appointments, etc.) or security clearances; financial harm due to lost clients; discrimination in divorce, child custody, or adoption hearings; decreased access to or increased costs of health and life insurance; embarrassment or social ostracism of family members; etc.

[43]Quoted in: Bill Wilson's New York Times Obituary. http://www.aahistory.com/aa/Bills_obit.gif

[44]Frank. A. (1995) *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: University of Chicago Press, p. xii.

[45]I would like to acknowledge John Magisano for calling this point to my attention.

The New Recovery Advocacy Movement, in calling on recovering people to "put a face on recovery" and offer "living proof" of recovery, is inviting a contingent of recovering people to tell their story to a new audience--not to themselves, to treatment professionals, or each other, but to the larger social community. And yet it will be important for members of the New Recovery Advocacy Movement to discuss how this public story should differ from the one shared in the counselor's office, in face-to-face mutual aid meetings, and in online support groups. At local and national levels, we need to ask ourselves the following questions:

1. What message do we want these stories to convey?
2. How can that message be best presented?
3. Who can best present this message?

When we move from mutual aid to recovery education/advocacy, we will need to redefine the meaning of "telling our story." We will need to stay message focused and avoid the temptation of overly dramatizing addiction and overly romanticizing recovery.

The New Recovery Advocacy Movement needs to convey a new language, new ideas, and new images about addiction recovery. We need to replace the flailing efforts of the cornered celebrity-addict to verbally extricate himself or herself from their latest public indiscretion with the more reasoned voices of those speaking not from a position of crisis but from a platform of stable and enduring recovery. The purpose of this storytelling is not emotional catharsis or anchoring one's own recovery. Instead, it is to: 1) send a message of hope to those still impacted by AOD problems, 2) place AOD problems in their larger context, and 3) form an emotional bridge between those in recovery and those who have never experienced AOD-related problems. The second of these goals requires depicting how society, through its misconceptions, misinformed policies, and inadequate resources has amplified the problems of addiction and inadvertently erected barriers to recovery. The third goal is to demystify addiction and recovery--to place addiction within the rubric of having experienced brokenness and separation from others. By placing addiction and recovery within the larger rubrics of adversity and the struggle to heal and be whole again, the separation--the "We-They" thinking--between addicted and recovering people and the larger community is bridged. The point of telling recovery stories publicly is not what it does therapeutically for the storyteller, but what it does to and for the listeners.

Responsibility, Gratitude, Service

I noted earlier that the New Recovery Advocacy Movement must find a fresh approach to enlist public support. While there are many rights issues that fall within the umbrella of this movement, I don't think appeals to injustices and rights will work with a citizenry that is losing its capacity to attend to new claims in this area. But there is a way that the New Recovery Advocacy Movement can present itself in a way that taps the core values of communities of recovery and, by doing so, bring something that is desperately needed in the larger culture. The emerging New Recovery Advocacy Movement is as much a responsibility movement as a rights movement. The message is a fresh one.

> *Through our addiction, we have wounded ourselves, our families and our communities. In gratitude for the gift of recovery, we declare our responsibility to manage our own recovery, to make restitution for the injuries we have inflicted on others, to carry a message of hope to others, and to contribute to the larger health of the community.*

The New Recovery Advocacy Movement would be well served by elevating the values of responsibility, accountability (restitution), and service and assuring that these values are expressed only on a voluntary basis.[46]

Friends of Recovery

Every movement to liberate or improve the lives of disempowered people brings people into the movement who are not members of this group, e.g., Whites playing supportive roles in the civil rights movement, men playing supportive roles in the women's movement. Some individuals are given "honorary" membership as "one of us" because of their empathy, their understanding, their commitment and their contributions to the movement. Some are so absorbed into the group that they lose nearly all aspects of their non-member status. Such people are in evidence in earlier recovery mutual aid and recovery advocacy movements. How are these special friends to be designated? Sociologists have referred to such people as "the wise"[47] while others have sometimes referred to them as "fellow-travelers". Perhaps such people could be referred to simply as "friends of recovery". The use of "friend" in this manner dates at least as far back as the Washingtonian revival of the 1840s.[48] The New Recovery Advocacy Movement will need and will have many such *friends of recovery*. I noted in an earlier paper that the leadership of this New Recovery Advocacy Movement should be authentic, and what I meant was that the leadership should come from those in recovery and their families. But technically, what is most important is that recovering people and their families choose their own leaders and that those leaders remain responsive to this constituency. There are places and circumstances where that leader will be a friend of recovery who is chosen by and represents the needs of the local recovery community.

Summary

There will be many strategies and tactics of the New Recovery Advocacy Movement. Language will be one method of altering the consciousness of those who make up this movement and altering the attitudes and beliefs in the community. As this New Recovery Advocacy Movement emerges, we must carefully assess and shape this language and then let that chosen language evolve as the Movement matures.

Somewhere in this movement's maturation, a message of unification must be forged that psychologically and socially links the growing number of recovery groups and solo flyers into communities of shared experience that can transcend their internal differences to speak powerfully on one issue: the hope and reality of permanent recovery from addiction. We need to find common ground of solidarity among those who were once afflicted but are today well and free. We must find a common recovery advocacy language that transcends the differences we have as groups and individuals. The most serious struggles need to be waged not with each other but with the more formidable forces in our communities and our culture that seek to objectify and demonize those who have experienced alcohol- and other drug-related problems.

[46]My emphasis on voluntary service is to head off any effort to enlist members in this movement through the vehicle of court-ordered community service.

[47]Goffman, 1963.

[48]Blumberg, L. with Pittman, W. (1991). *Beware the First Drink!* Seattle: WA: Glen Abbey Books.



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). Recovery as heroic journey. Perspectives: A Journal on Addiction Research and Public Policy, 12(3), 2.

White, W. (2002). The boon of recovery. Perspectives: A Journal on Addiction Research and Public Policy, 12(4), 2.

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, pp. 79-84.INSERT
Posted at **www.williamwhitepapers.com**

Recovery as a Heroic Journey

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

In his classic work, The Hero with a Thousand Faces, Joseph Campbell described a dominant myth pervading the world's cultures. Campbell noted that, in spite of their myriad variations, mythic stories of the heroic adventure shared a common structure: the hero's departure, the hero's transformation by great trials, and the hero's return. Campbell's portrayal of the heroic journey beautifully depicts the metamorphoses of addiction and recovery at the same time it poses provocative questions about the final stage of the recovery process.

The beginning of the hero's tale is the call to adventure. Here the yet-to-be hero, often a person of little note or a community outcast, responds to a call from beyond his or her parochial world. To answer this call requires leaving that which is familiar to enter regions of "both treasure and danger." The call to adventure marks a great separation from family and community and entry into an unknown world.

As the adventure unfolds, the hero encounters numerous trials and tribulations that test his or her character. Eventually, the hero experiences an ultimate test. It is here that the hero is "swallowed into the unknown, and would appear to have died." But the hero, often with the aid of a personal guide, finds a way to escape, whether from the labyrinth or the monster's belly. The death experienced by the hero turns out to be not a death of the body but a living death of the ego. It is in this transformation that the hero recognizes and embraces new sources of power and understanding and is reborn into a new consciousness and a new relationship with the world. The central part of the heroic tale involves the acquisition of new knowledge that turns out to be as much

rediscovery as discovery. Campbell notes: “the powers sought and dangerously won are revealed to have been within the heart of the hero all the time.”

According to Campbell, the most difficult stage of the hero’s journey is the return home. This is a stage of reentry into the community that was left behind, reconciliation between the hero and the family/community, and a stage of service through which the hero delivers the gift of his/her newfound knowledge to the community. To complete the heroic journey, the hero who left the community as a seeker must return as a servant and teacher. Campbell notes that the task of fully returning is so difficult that many heroes fail to complete this final step of their journey.

There are obvious parallels between the processes of addiction and recovery and the structure of the hero’s tale. There are hundreds of thousands of people whose recovery stories share striking similarities to Campbell’s myth of the hero. My primary purpose for exploring this similarity is to explore one aspect of this comparison: what the hero’s return to the community implies as a task of late stage recovery. Several questions arise from Campbell’s discussion. Have recovering people returned to their communities to share the boon (gift of knowledge) of their adventure? How can this return be completed? What is the nature of this boon that can help the community work out its own salvation?

Returning to the community calls not just for a physical and social re-entry into the community, but also for acts of reconciliation (healing the wounds inflicted upon the community, forgiving the community for its own transgressions), and giving something of value back to the community. For the heroic journey to be completed, for the hero to reclaim his or her citizenship in the community, those debts and obligations must be paid. Left unpaid, the hero’s final act of fulfillment remains unconsummated. Left unpaid, the community loses experience and knowledge that could enhance its own health and resiliency.

The boon of the heroic journey can be offered individually through acts of restitution, by carrying a message of hope to others (sharing one’s “story”), and by modeling the lessons contained in the boon (practicing recovery principles in our daily lives). And yet the questions could be asked: Have recovering people as a group fully returned to their communities or are they hiding within those communities? Are recovering people as a group reaching out or have they escaped into the comfort and security of their own recovery?

The stigma of addiction--the price that even those in long-term recovery can pay in disclosing this aspect of their personal history--leads many recovering people to “pass” as a “normal,” scrupulously hiding their recovery journey from members of the larger community. Some recovering people live a socially cloistered existence, interacting almost exclusively with others in recovery. Does such isolation constitute a failure at re-entry, a missed opportunity for reconciliation, and an abdication of the responsibility to teach and serve the community?

These questions are not easy to answer because recovering people and their styles of recovery and styles of living are extremely diverse. There are clearly recovering individuals who have achieved Campbell’s stages of re-entry, reconciliation, and service.

If recovering people have not fully returned to their communities, it is as much a cultural failure as a personal one. It is the cultural stigma--the very real price that can be exacted for disclosure of recovery status--that is a primary culprit here. It is time for a new recovery advocacy movement that, by removing the cultural stigma that continues to be attached to addiction/recovery, can open the doors for recovering people to return to their communities. It is time recovering people shared the boon of their recovery, not just with others seeking recovery, but with the whole community.

There is a new recovery advocacy movement afoot in America that promises greater contact between recovering people and the larger community. Recovering

people around the country are again creating grassroots organizations aimed at supporting recovery through advocacy, community education, and recovery resource development. The participants in this New Recovery Advocacy Movement, while responding to critical community needs, are finding in this recovery activism a way to complete their own personal journeys. They are finding ways to return and serve their communities.

Coming Next: What is the nature of this gift of knowledge that recovering people possess and that their communities need?

The Boon of Recovery

William L. White

In an earlier article entitled "Recovery as a Heroic Journey," I summarized mythologist Joseph Campbell's cross-cultural study of hero myths, and compared his depiction of the heroic journey to the processes of addiction and recovery. Campbell described how these myths typically unfolded in three stages: the hero's departure from family/community, the hero's transformation through great trials and tribulations, and the hero's return. My focus in that article was on the final of these stages. Campbell contended that the heroic adventure remained unfulfilled until the hero accomplished the most difficult task: returning to pass on the boon (gift of knowledge) of his adventure to the community. My discussion of Campbell's work raised the question of whether recovering people as a group had returned to their communities or whether they were hiding in those communities. The article ended with a call for recovering people to explore how they could pass on the boon of their recovery to the community and suggested that the work within the New Recovery Advocacy Movement might provide a vehicle to complete that heroic adventure. In this article, I will explore the exact nature of that boon of recovery.

The most obvious gifts of knowledge that recovering people can bestow on their communities are their stories—stories that unveil the experience of addiction, stories that communicate the reality and hope of full recovery, and stories detailing their knowledge of how such recovery can be initiated and sustained. Five ideas about recovery need to be inculcated within communities across America.

1. Addiction recovery is a reality.
2. There are many paths to recovery.
3. Recovery flourishes in supportive communities.
4. Recovery is a voluntary process.
5. Recovering and recovered people are part of the solution; recovery gives back what addiction has taken.

Those alone are worthy gifts, and ones that the New Recovery Advocacy Movement is calling upon recovering people to give to their communities. But there may be larger, more difficult to define gifts that could benefit communities across the world. Such gifts are not about how to recover from addiction, but rather what recovery from addiction has taught recovering people about life and how to live it. There are many gifts that recovering people could bestow on the larger society.

Many recovering people reach a stage in their recovery where addiction is reframed from a curse to a gift-bestowing blessing. Civilians (those not in recovery) who have had close contact with recovery groups have often lamented that it is too bad one has to be an addict to reap the benefits of recovery. The endless application of recovery programs to problems other than addiction surely suggests something of value here that far transcends their original intent. For years I have been asking those in long-term recovery what they most value about their recovery experience. Most surprising is the number who describe recovery, not as their greatest achievement, but the foundation or by-product of that achievement. Their responses reveal more about how to live than how not to drink or use other drugs. Collectively, these voices say

that, through their close encounters with death (of body or self), they have come to understand both the fleeting transience and preciousness of life, and, as a result, the importance of living every moment as a gift to be cherished and lived to its fullest. Those experiencing terminal illnesses have often shared a similar observation. What makes those in recovery unique is that they constitute what might be called a Lazarus Society or a Phoenix Society of men and women who, in the face of utter personal destruction, have not only survived but been reborn, often with decades of life to live, to serve, to teach. The members of this Society, in their most retrospective moments, speak of the experiences and aspirational values that became important in their lives through the experience of addiction recovery. They speak of the importance of:

- ✓ Living in the present (Acceptance)
- ✓ Paying attention (Awareness)
- ✓ Listening (Empathy, Respect for Elders)
- ✓ Recognizing oneself in others (Identification; Unity of all People)
- ✓ Relating (Connectedness)
- ✓ Creating community (Participation, Belonging)
- ✓ Acknowledging limitations and imperfections of character (Self-knowledge, Humility)
- ✓ Believing (Faith, Hope)
- ✓ Staying focused (Vision, Centeredness)
- ✓ Accepting limitations of time (Patience, Perseverance)
- ✓ Paying debts (Restitution)
- ✓ Saying “I’m Sorry” (Forgiveness)
- ✓ Saying “Thank You” (Gratitude)
- ✓ Telling the truth (Honesty)
- ✓ Telling one’s story (Witness)
- ✓ Respecting privacy (Discretion)
- ✓ Keeping promises (Fidelity)
- ✓ Laughing (Humor)
- ✓ Celebrating (Joy)
- ✓ Avoiding complications and distractions (Simplicity)
- ✓ Doing one’s duty (Responsibility)
- ✓ Giving and helping (Service)
- ✓ Accepting differences (Tolerance)

The stories of recovering people also speak of what they have come to believe are the poisons of the human spirit: such things as self-deception, self-conceit, self-centeredness, jealousy, bigotry, resentments, anger, gluttony, avarice, and callousness.

This all stands as an interesting blend of surrender and assertion, reaching inward and outward, reconstruction of self and, perhaps in the future, the reconstruction of communities. The recovery message embraces the ethic of personal responsibility--the power of personal action--while simultaneously affirming the power of acceptance and surrender and acknowledging that the most important things in life cannot be achieved alone but only in the context of relationship. If that sounds contradictory, an appreciation of such paradoxes is also part of the boon of recovery.

The New Recovery Advocacy Movement is calling for recovering people to return to their communities and deliver the boon of recovery. The first task will be that of recovery education and advocacy, but a day may come when recovering people will pass on the deeper lessons of that boon to the larger community. On that day, the community will have received a great gift. On that day, recovering people will have come home. They will, in Campbell’s terms, have completed their heroic journey.



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). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Posted at **www.williamwhitepapers.com**

The History and Future of Peer-based Addiction Recovery Support Services

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Executive Summary

History Within the addictions arena, there is a long and rich history of recovery mutual aid societies, peer-based recovery support groups, and the use of recovered/recovering people in paid service roles from which lessons can be drawn.

Origin Peer-based recovery support services (P-BRSS) are emerging from:

- research confirming the limitations of existing treatment models,
- calls to reconnect treatment to the more enduring process of addiction recovery,
- a shift from pathology and treatment paradigms to a recovery paradigm, and
- a shift from acute care to models of sustained recovery management.
-

Rationale Peer-based service models are based on sound psychological principles, have been tested in multiple environments (including addiction treatment settings), and are grounded in the aspirational values of local communities of recovery.

Issues Critical issues in the design and implementation of P-BRSS services include:

- questions of power and control (e.g., who gets to define peer?);
- the variability and lack of empirical testing of P-BRSS models;
- P-BRSS role and definitions and credential requirements;
- the multiplicity of role demands placed upon the P-BRSS specialist;
- adapting P-BRSS to emerging knowledge on the pathways, styles and stages of long-term addiction recovery; and
- integrating P-BRSS with the treatment continua of care and linking P-BRSS to indigenous recovery support structures.

Benefits and Risks Theorized benefits of P-BRSS will require empirical validation, and care will be needed to avoid unintended harm of P-BRSS to service consumers, service providers, service organizations and local communities of recovery.

Obstacles There are conceptual, emotional, technical, administrative and fiscal obstacles that will have to be overcome before P-BRSS services emerge as a widely available resource in American communities.

Recommendations Action recommendations include:

- Develop national and state recovery support infrastructures that span inter-related problems (addiction, mental illness AIDS) and serve as a resource for the development of local P-BRSS
- Develop models of successful collaboration between P-BRSS, indigenous mutual aid groups, professionally-directed addiction treatment services, and other health and human services
- Develop ethical and relationship guidelines for the delivery of P-BRSS
- Conduct controlled studies (multi-site randomized clinical trials) that evaluate the long-term effects of P-BRSS on recovery outcomes and the impact of P-BRSS on indigenous recovery support groups and the larger community.

P-BRSS models could be a superficial appendage to the treatment system or an instrument that triggers the broader transformation of that system. P-BRSS services will be a boon if they widen the doorways of entry into recovery and enhance recovery quality and durability. If P-BRSS models inadvertently lead to the commercialization and erosion of the service ethic within communities of recovery and an ever-growing recovery support services industrial complex, this experiment will have failed horribly.

The History and Future of Peer-based Addiction Recovery Support Services

William L. White, MA[1]

Introduction

The intent of this paper is to outline issues and recommendations related to the design, development, and evaluation of peer-based[2] recovery support services (P-BRSS) within the addictions field. Two introductory points are warranted. First, exploring P-BRSS requires use of a recovery-oriented language that has been defined in the text, within footnotes, or defined and discussed in a published recovery glossary (White, 2002a) posted at www.bhrm.org. Second, the necessity to tightly condense complex ideas within this paper calls for encouragement of the reader to further explore the cited and recommended resources.

[1] William White, the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America,* is a Senior Research Consultant at Chestnut Health Systems and Associate Director of the Behavioral Health Recovery Management project. He has served on the boards of Recovery Communities United, the Alliance for Recovery, and Wellbriety for Prisons, Inc., and provided consultant to numerous recovery advocacy and recovery support organizations.

[2] The term 'peer" is used here rather than "consumer." The latter implies support services provided by someone who is or has been a recipient of professionally-directed treatment services. In the addictions arena, recovery support services may be provided by persons in recovery, or otherwise defined as an ally by those receiving help, who have not been "consumers" of treatment services. Use of the term "peer" rather than "consumer" reinforces that there are multiple pathways to recovery, not all of which involve professionally-directed addiction treatment, and affirms an identity linked to a community of recovering people rather than a treatment institution.

Background

History of Addiction Recovery Mutual Aid[3] Societies Addiction recovery mutual aid societies have a rich history spanning 18th and 19th century Native American "recovery circles" (abstinence-based healing and religious/cultural revitalization movements), the Washingtonians (1840s), fraternal temperance societies (1840s-1870s), ribbon reform clubs (1870s-1890s), Drunkard's Club (1870s), United Order of Ex-Boozers (1914), Alcoholics Anonymous (AA) (1935), Alcoholics Victorious (1948), Narcotics Anonymous (1953) and other Twelve-Step adaptations, adjuncts to AA (Calix Society, JACS), alternatives to AA (e.g., Women for Sobriety, Secular Organization for Sobriety, LifeRing Secular Recovery), the Wellbriety Movement in Indian Country, and faith-based recovery ministries (particularly within African American communities) (White, 1998, 2001a; Coyhis & White, 2002; Sanders, 2002).

History of Peer-based Social Support Linked to Addiction Treatment Peer-based social support linked to addiction treatment institutions span patient clubs developed within inebriate homes and asylums (Ollapod Club, the Godwin Associations) and adduction cure institutes (Keeley Leagues)(1860s-1890s), the Jacoby Club of the Emmanuel Clinic in Boston (1910), AA "wards" (in hospitals) and "farms" (1940s-1950s), halfway houses (1950s) and self-managed recovery homes (e.g., Oxford Houses), treatment program volunteers, California's "social model" programs,[4] treatment center "alumni associations," and new peer-based support models developed by the Center for Substance Abuse Treatment's Recovery Community Support Program grantees (White, 1998, 2001a).

History of Paid Peer Helpers The use of paid peer helpers (people in recovery hired to serve as guides for others seeking recovery) in the addictions arena spans recovered and recovering[5] people working as temperance missionaries (1840s-1890s); aides ("jag bosses") and managers of inebriate homes (1860s-1900); Keeley Institute physicians (1890-1920); "friendly visitors" within the Emmanuel Clinic in Boston (1906); lay alcoholism psychotherapists (1912-1940s); managers of "AA farms" and "AA rest homes" (1940s-1950s); halfway house managers (1950s); "paraprofessional" alcoholism counselors and professional "ex-addicts" (1960s-1970s); credentialed addiction counselors; detox technicians, residential aids, outreach workers, and case managers (1970s-1990s), and, more recently, "recovery coaches," "recovery mentors," and "recovery support specialists" (White, 1998, 2000c). There are states (CT, AZ) that are working to systematically include P-BRSS as part of a reconfigured continuum of addiction treatment services care and at least one state (PA) that is already investigating the credentialing of recovery support specialists.

Geographical Range Addiction recovery mutual aid groups and peer-based support models are an enduring international phenomenon reflected in the international growth of AA and NA and in such recovery mutual aid movements as the Blue Cross (Switzerland, 1877), the Kreuzbund (Germany, 1885), Croix d'Or (France, 1910), Zukunft/Abstinence Union (Austria, 1926), Swedish Links (1945), Vie Libre (France, 1953), Polish Abstainers Club (1960), the Danshukai movement (Japan, 1963) and the Pui Hong Self-Help Association (China,1967) (Humphreys, 2004; White, in press).

Conditions Spawning P-BRSS Historically, addiction-related P-BRSS have been sparked by the:

- inadequacies of professionally-directed interventions (the failure to consistently provide recovery-oriented services characterized by accessibility, affordability, quality and continuity of support)

[3] These groups are here referred to as "mutual-aid" groups rather than "self-help" groups as they technically are not self-help, but an admission that efforts at self-help are exhausted, requiring a reliance on resources and relationships that transcend the self (Miller & Kurtz, 1994).

[4] See special issue of *Journal of Substance Abuse Treatment* Volume 15, Number 1, 1998.

[5] See White, 2002a for the distinctions between these two terms.

- failure to fully legitimize and facilitate multiple (including gender-specific, culturally-nuanced, medication-assisted) pathways of entry into recovery, and the
- belief that treatment has become disconnected from the larger, more enduring and socially-mediated process of addiction recovery (White, 2001b; 2002b; 2003a; 2003b).

As peer-based services seek to link themselves to the existing treatment system, there will be pressure to emulate the treatment system and its professional roles. Great care must be taken to preserve that which is unique and authentic within P-BRSS.

Rationale P-BRSS in the addictions arena are based on the following propositions:

- Helpers derive significant therapeutic benefit from the process of assisting others (the "helper principle") (Reisman, 1965, 1990; recovery slogan: "To get it, you have to give it away.").
- 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.
- The inadequacy of acute care models of treatment for people with high problem severity and complexity is evident in low engagement rates, high attrition rates during treatment, low aftercare participation, and high re-admission rates.[6]
- Persons with high personal vulnerability (family history, low age of onset of use, traumatic victimization), AOD problem severity and complexity (co-morbidity) and low "recovery capital"[7] do not fare well in acute models of intervention but can achieve recovery when provided sustained support. (P-BRSS constitute an essential element within new models of sustained recovery management) (White, Boyle and Loveland, 2002, 2003).[8]
- Many addicted people benefit from a personal "guide" who facilitates disengagement from the culture of addiction and engagement in a culture of recovery (White, 1996).
- 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.
- P-BRSS are an attempt to re-link treatment and recovery (Else, 1999; White, 2000b), to move the locus of treatment from the treatment institution into the natural environment of those seeking treatment services (White, 2002a), and to facilitate the shift from toxic drug dependencies to "prodependence on peers" (Nealon-Woods, et al, 1995).

P-BRSS services are congruent with research findings that[9]:

- Addiction recovery begins prior to the cessation of drug use; is marked in its earliest stages by extreme ambivalence; is sustained long after the period of initial stabilization of sobriety; involves different types of age-, gender-, and culture-mediated change processes; and is often marked by predictable stages of change.
- The achievement of stable recovery is determined, in part, by recovery capital that can be enriched through support services.
- Factors that sustain recovery are different than those that initiate recovery.

---

[6] In 1999, 1,346,759 people were admitted to publicly funded treatment, 58% having been in treatment before (23% once, 23% two to four times, and 12% five or more times) (Office of Applied Studies, 2001).

[7] Recovery capital is the total amount of internal and external resources that an individual, family or community can bring to bear on the initiation and maintenance of recovery (Granfield & Cloud, 1999.

[8] RM models will fundamentally change P-BRSS linked to addiction treatment. The addictions field has a long history of employing former clients in service roles, but RM's shift to prolonged, low intensity recovery supports will mean that addiction treatment agencies, like their mental health counterparts, will be potentially hiring some persons who currently receive services at the agency, making them both service consumers and service providers. The ethical/boundary issues raised by such role duality are numerous and complex. The successful ways such issues are being managed in the mental health field and AIDS service community offer a source of fruitful collaboration.

[9] See White, Boyle, Loveland (2002) for a review and citations.

- Push factors (pain) and pull factors (hope) both play a role in the recovery process; P-BRSS have a direct effect on the latter.
- The point at which most recoveries become fully stabilized is between four and five years—suggesting the need for a system of sustained monitoring and support.
- Long-term recovery is mediated by processes of social support.

An extensive body of research suggests the potential effectiveness of peer-facilitated models of change (Durlak, 1979; Hattie, et al, 1984; Riessman, 1990), particularly within the arena of addiction recovery (Connett, et al, 1980; Galanter, et al, 1987; Blum and Roman, 1985).

Values Values governing P-BRSS should be extracted from a larger set of values guiding a "recovery-oriented system of care" (For sample, see **http://www.dmhas.state.ct.us/corevalues.htm**). Values that have been emphasized within the deliver of P-BRSS within the addictions arena include a focus on potential (strengths, resilience) rather than problems (pathology), empowerment rather than paternalism, a respect for diverse pathways and styles of recovery, a preference for voluntary versus coerced participation, a focus on wellness/wellbriety/global health versus a singular focus on abstinence, involvement (of recovering people in P-BRSS policy development), inclusiveness (reaching out to multiple ethnic/religious/recovery communities), the need to confront stigma at personal and cultural levels, and the need to integrate clinical and advocacy/community development models that focus on the ecology of recovery (enriching recovery capital within families, communities, and nations) as well as the personal dynamics of recovery. Overriding all of these is the primacy of recovery: the quality of P-BRSS to others is contingent upon the quality of one's own recovery.

Key Issues and Discussion

Definition of "Peer" A most critical issue in the design and delivery of P-BRSS is the question of who defines *peer*. There is growing consensus that it is the right of recipients of P-BRSS services to define *peer*. *Peer* is most often defined in terms of recovery status (knowledge of recovery from the inside—as a recovering person or family member or someone vetted inside the community as having expertise as a recovery guide). It may also include qualities essential to the service alliance (e.g., shared gender, ethnicity, religious orientation, developmental experiences, or accountabilities to the same community).

Peer Credentials Persons providing P-BRSS, rather than being legitimized through traditionally acquired education credentials, tend to be legitimized based on *experiential knowledge* and *experiential expertise* (Borkman, 1976). It is not the experience of having been wounded or having transcended such wounds that constitutes a credential. It is the extraction of lessons from that experience (distinguishing the universal from personally unique aspects of recovery) that can aid others, and a new ethic that transforms that learning into service to others. Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. Experiential expertise requires the ability to use this knowledge to affect sustainable change in self or others. It requires the ability to separate the experience of the helper from that of the person being helped. The dual credentials of experiential knowledge and experiential expertise are granted through the addiction/recovery community "wire"/"grapevine" via storytelling. It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community (White & Sanders, forthcoming).

P-BRSS Model Variations P-BRSS may be delivered within a clinical model (that views the recovery support specialist as a treatment aide) or a community development model (that views the support specialist as an organizer and mobilizer of community recovery resources). P-BRSS services may be delivered within an acute care (AC) model of treatment (crisis intervention, clinical stabilization, and recovery initiation) or within a model of recovery management (RM) models that emphasizes a more sustained continuum of pre-recovery, recovery initiation and recovery maintenance support services. RM models are particularly

distinguished by sustained recovery monitoring (including recovery checkups), stage-appropriate recovery education, active linkage to indigenous communities of recovery, and early re-intervention (White, Boyle & Loveland, 2002,2003). P-BRSS services can be based on a pathology model (focus on solving problems) or on a strengths (resistance/resiliency/wholeness) model (focus on building recovery capital within the individual, family and community). P-BRSS services may be delivered as an adjunct to other service roles (e.g. counselor, case manager, or outreach worker) or may be delivered within a specialized paid or volunteer role. P-BRSS services may be delivered within existing treatment institutions, delivered by other local community institutions (church, school, labor union) or delivered by a grassroots recovery advocacy or recovery support organization.

Types of P-BRSS (Service Menu) The range of services provided with the framework of P-BRSS is indicated by the broad range of roles being proposed within "recovery coach" pilot studies. 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)
- lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living)
- a friend (provides companionship).

Equally important, the P-BRSS specialist is NOT a:

- sponsor (does not perform AA/NA service work on "paid time")
- therapist (does not diagnose, probe undisclosed trauma/"issues"; does not refer to their support activities as "counseling" or "therapy")
- nurse/physician (does not make medical diagnoses or offer medical advice), or a
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church)[10].

The verbs most frequently used to describe P-BRSS include the following: engage, elicit, validate, share, express, enhance, orient, help, identify, link, consult, monitor, transport, praise, enlist, encourage, and support. The fact that P-BRSS specialists fulfill all these roles and functions is both a strength and vulnerability of P-BRSS models.

P-BRSS and Pathways of Recovery P-BRSS services are best delivered within the recognition of multiple long-term pathways of recovery (White, 1996). The practical implications of this proposition is that the recovery support specialist must:

- recognize the legitimacy of these multiple pathways

[10] P-BRSS specialists draw from an eclectic menu of religious and secular concepts and metaphors to anchor the recovery process.

- become conversant with the language, catalytic metaphors[11] and rituals reflected within these pathways
- work to expand the variety of recovery support structures within the communities he or she serves, and
- develop relationships with the myriad groups representing these pathways.

P-BRSS and Style of Recovery P-BRSS are best delivered within the recognition of multiple styles of recovery. Such style variations are reflected in the recovery process (transformative change[12] versus incremental stages of change), identity reconstruction (recovery-positive versus recovery-neutral identity), and post-recovery interpersonal relationships (acultural, bicultural and culturally enmeshed styles of recovery)(White, 1996). The operational motto of the best P-BRSS specialists is "recovery by any means necessary." It matters little to them whether recovery is initiated without professional assistance (solo or natural recovery), with peer-assistance or professional treatment (affiliated or assisted recovery), or is initiated via peer and professional supports but maintained without such assistance (disengaged recovery) (White, 2002a). The focus is on the goal, not the method. Such tolerance and respect requires maturity and wisdom.

P-BRSS and Stages of Recovery P-BRSS services (particularly within recovery management models) are based on the following assumptions:

- There are predictable stages in the long-term process of addiction recovery.
- Service and support services that are crucial in one stage may be unhelpful or even harmful at another stage.
- Service and support needs must be continually reassessed via sustained dialogue with the person in recovery (monitoring, assessment of recovery quality and stability, recovery plan refinement).

P-BRSS and the Existing Continuum of Treatment he current addiction treatment continuum of care that focuses on crisis intervention and recovery initiation needs to be reconfigured with pre-treatment recovery support services, in-treatment recovery support services (to enhance engagement and reduce attrition) and post-treatment monitoring and stage-appropriate support services. The emphasis is on the transfer of institutional learning and anchoring recovery within the natural environment of the client. There is a danger that P-BRSS will evolve as a separate system disconnected from the national network of addiction treatment programs. P-BRSS are coming out of a new generation of grassroots recovery advocacy and support organizations who perceive many treatment programs as more concerned about their own institutional interests than the long term recovery outcomes of those they serve. This undercurrent of disenchantment and hostility and its sources will need to be openly confronted and resolved if the goal of a system of integrated clinical treatment and recovery support services is to be achieved. Lacking such resolution, the proliferation of P-BRSS and their alienation from mainstream treatment could further fragment a system that is already difficult to navigate. The following principles are suggested as a foundation for such collaboration.

- P-BRSS and professionally-directed addiction treatment services are complimentary rather than competitive.
- P-BRSS and TX services must be integrated into a single, seamless continuum of services.
- P-BRSS specialists and treatment specialists must recognize and respect the special contributions each can make to the recovery process.

[11] Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite change in beliefs, behavior, identity and relationships.

[12] Transformative change is characterized by its suddenness, vividness, positiveness and permanence (Miller and C'de Baca, 2001).

- Both P-BRSS specialist and treatment specialists must accurately represent and practice within the boundaries of their education, training and experience.[13]
- The goal is to have all services—professional and peer--become person-oriented, family-oriented and recovery-oriented.

P-BRSS and Existing Sobriety-Based Support Groups The effects of P-BRSS on existing recovery mutual aid societies is unknown. There is reason to believe that such services will increase engagement and reduce attrition within such societies and that organizations providing P-BRSS services will find ways of developing working relationships with such groups, but harm to such groups could flow from P-BRSS (See below discussion).

Strengths and Vulnerabilities of P-BRSS Models P-BRSS services will require extensive evaluation to determine their effects on addiction and recovery careers. There will be particular interest in how P-BRSS can enhance the effectiveness of the existing treatment system. Testing the following hypotheses would be a good starting point for such research. P-BRSS services can:

- increase the number of people entering addiction treatment
- decrease the number of people "lost" from waiting lists to enter addiction treatment
- divert individuals with lower problem severity and higher recovery capital into natural recovery support systems in the community (creating a better stewardship of limited treatment resources)
- enhance treatment retention and completion
- increase post-treatment abstinence outcomes
- delay the time period from discharge to first use following treatment (enhancing development of recovery capital)
- prevent lapses from becoming relapses
- shorten the number, intensity, and duration of relapse episodes following treatment
- decrease treatment readmission rates (slow the revolving door of treatment)
- decrease the time between relapse and re-initiation of treatment and recovery support services (preserving recovery capital and minimizing personal and social injury)
- result in readmission to less intensive, expensive levels of care
- reduce attrition in first year affiliation rates with AA and other sobriety-based support groups
- enhance recovery capital (e.g., employment, school enrollment, stable housing, healthy family and extended family involvement, sobriety-based hobbies, financial resources) and self-defined quality of life.

At a systems level, P-BRSS offer an opportunity to enhance linkages between the existing treatment agencies and local indigenous recovery support systems—linkages that have eroded through the commercialization of addiction treatment. P-BRSS roles may also offer an opportunity to retrieve the best of what was lost on the road to professionalizing the role of addiction counselor, e.g., a service relationship based on moral equality, practical recovery coaching, knowledge of and active linkage to local communities of recovery.

The strengths and vulnerabilities of P-BRSS are integrally connected. The values of accessibility and working within natural environments has a shadow side of over-extension, burn-out and concerns about the physical and psychological safety of P-BRSS specialists. The

[13] This must be based on mutual respect and the recognition that some services are best provided by traditionally trained professionals while others are best provided by peer specialists. The expectation of respect for boundaries of competence applies to both roles.

reciprocal, non-hierarchical nature of the P-BRSS relationship leaves open the danger of boundary violations and hidden abuses of power. The emphasis on continuity of support over time leaves agencies providing P-BRSS struggling to define their recovery support capacity (How many people can be supported in what manner for how long?) The values of client empowerment and rebellion against the growing coerciveness of addiction treatment run headlong into dilemmas of how to respond when those we serve pose threats to others. The grassroots P-BRSS movement will need to actively manage the inevitable pull towards specialization, professionalization and commercialization. Confronting ineffective practices in the existing treatment system, including those within agencies that are experimenting with P-BRSS, and being viewed as competition for scarce funding resources will also align the P-BRSS movement against powerful institutional and professional interests.

The P-BRSS movement will also need to confront how addiction-related stigma can distort its own operations as an organization or organizational unit, potentially leading to "incestuous closure," the scapegoating of organizational/unit leaders and members, the exploitation of organizational/unit members, and organizational/unit stagnation and implosion (See White, 1997; Janzen, 2001).

Potential Iatrogenic Effects of P-BRSS The history of addiction treatment is filled with iatrogenic insults (treatment-caused harm or injury)[14], and the potential for such effects with P-BRSS requires active prevention and management.

Risk to Service Consumers Consumers of recovery support services could be injured from incompetent care and through boundary violations (financial, emotional, and sexual exploitation) in their relationships with P-BRSS service specialists. P-BRSS may require a set of protections analogous to those provided upon entry to addiction treatment (e.g., credentialing, codified ethical standards and complaint procedures, informed consent, confidentiality, clinical supervision).

Risk to P-BRSS Providers There are several potential risks to the providers of P-BRSS, e.g., vulnerability for exploitation (excessive hours, low pay/benefits/status; abuses of power in the relationships between P-BRSS specialists and professionals), alienation/isolation from recovery community, vulnerability for relapse--particularly in organizations or work environments not conducive to personal recovery. (Such exploitation and vulnerability of recovering people working in service roles is a hidden story in the rise of modern addiction treatment) (White, 1979, 1998).

Risk to Service Organizations Service organizations will face liability risks related to improper hiring, supervision and retention of P-BRSS workers who are involved in illegal or unethical conduct. Such liability will need to be actively managed via rigorous screening and hiring procedures, rigorous training and supervision and the development of codes of ethical conduct governing the delivery of P-BRSS.

Risk to the Community P-BRSS could also injure the larger recovery community by engendering conflict about such services within mutual aid organizations and by undermining or commercializing the service ethic within such organizations. The goal of P-BRSS services is to exponentially expand natural recovery support services within each community, not replace voluntary support services with paid services. If the result of P-BRSS services is the latter, the harm will be a significant one. If five years following the implementation of P-BRSS a community has more paid peers but fewer sponsors and weaker sponsorship rituals within AA/NA and other mutual aid societies, then the P-BRSS model will have failed horribly.

[14] Such iatrogenic insults include mandatory sterilization, indiscriminate application of chemical and electrconvulsive therapy, harmful drug therapies, prolonged sequestration, profane confrontation and humiliation, and financial exploitation, to name a few.

Implementation Obstacles The barriers to implementing P-BRSS are substantial and span obstacles that 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)
- administrative (challenges complying with treatment-oriented licensing and reporting procedures), and
- fiscal (lack of financing models for P-BRSS, cuts in treatment-related services due to state fiscal austerity).

Evaluation of Peer-Based Services The evaluation of P-BRSS is part of a larger recovery research agenda within the addictions arena—an arena that has amassed considerable research on the nature of psychoactive drugs and addiction and the effects of treatment, but which knows very little about the prevalence and processes of long-term addiction recovery. The evaluation of P-BRSS services needs to be encompassed in the larger agenda of charting the long-term pathways, styles and stages of recovery and the processes that mediate full and partial recovery. P-BRSS need to be subjected to rigorous scientific evaluation, but their evaluation should also be conducted by recovery community elders addressing the question, "What has our experience taught us about the short- and long-term effects of P-BRSS services on individuals, families, and local communities of recovery?"

Action Items and Recommendations

Recovery Support Infrastructure

- Establish a National Recovery Resource Center to serve as a clearinghouse for recovery research, recovery support models, and P-BRSS-related training and consultation services (The Center's mission should span recovery from over-lapping problems areas--addictions, mental health, AIDS.)
- Provide opportunities for representatives from local P-BRSS organizations to assemble regionally and nationally and to participate in an internet-based system of information exchange
- Support the development and quality of P-BRSS services via development and dissemination of concept papers, organizational tools (how to create a P-BRSS organization and work with a local P-BRSS board; how to develop P-BRSS within an existing treatment agency), role qualifications and hiring procedures, sample grant proposals, model service protocol, etc.[15]
- Explore development of P-BRSS services as a formally recognized level of care within the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance-related Disorders
- Develop models for the funding and reimbursement of recovery support services, assessing both the advantages and problems (e.g., over-professionalizing P-BRSS; drowning P-BRSS in paper and procedures) associated with particular models
- Make federal funding of addiction treatment agencies contingent upon inclusion of or linkage to P-BRSS and inclusion of recovered/recovering individuals/family members on their policy-making boards

[15] What I am calling for here is the development of resources similar to those to that have been beneficial to the mental health consumer/survivor movement, e.g., Mowbray, C., Moxley, D., Jasper, C. and Howell, L. (1997) *Consumers as Providers in Psychiatric Rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

- Conduct a special exploration of the potential of P-BRSS for persons involved in methadone maintenance treatment (MMT), including an exploration of how the social and professional stigma associated with MMT (even within the worlds of addiction treatment and recovery) have slowed the development of MMT-related P-BRSS and how such services might be particularized to that setting

Model Definition, Development, and Dissemination

- Create local venues in which "peer" qualifications can be defined and values and standards developed that can guide the delivery of P-BRSS
- Poll P-BRSS organizations to evaluate the pros and cons of credentialing P-BRSS roles and to discuss such issues human resource issues as compensation scales, benefit modifications, career ladders, etc.
- Develop model support procedures for the transition from person in recovery to peer service specialist, e.g., P-BRSS orientation and training curricula
- Develop supervisory protocol for P-BRSS procedures that address such issues as relationship boundary management, safety management, the fragile balance between service responsiveness and self-care, and that address issues raised in supervision from an employee development framework rather than a therapeutic framework
- Develop model policies and protocol for responding to impairment (e.g., lapse/relapse) of peer specialists
- Define processes through which organizations providing P-BRSS can articulate organizational values (equivalent to AA's Twelve Traditions) that can guide programmatic and service decision-making and guide the organization's relationship with local communities of recovery
- Extract (from accumulating experience) different models of linking P-BRSS services to particular levels of care within the existing system of addiction treatment
- Pilot, evaluate and disseminate the findings of open-ended (designed to rapidly evolve in response to changing consumer needs and accumulated experience) P-BRSS initiatives in different cultural and geographical contexts, different institutional settings, and with different demographic and clinical subpopulations

Models of Collaboration

- Develop and disseminate case studies and models of successful collaboration that integrate P-BRSS, support provided by indigenous mutual aid groups, professionally directed addiction treatment services, and other health and human services
- Develop models of collaboration between mutual aid service structures (Central Offices, Intergroups, H & I committees, etc.) and P-BRSS organizations/units

Ethics of P-BRSS

- Convene a national meeting of P-BRSS organizations across problem arenas (addictions, mental health, AIDS) to define a process/model through which local programs can define core values and practice codes to guide the delivery of P-BRSS
- Collect and distribute statements of values and practice standards emerging from local P-BRSS programs
- Develop an ethics casebook that can be used in the training of P-BRSS specialists (For prototype, see White & Popovits, 2002).

Evaluation

- Locate and celebrate exemplary models in which service consumers play a central role in the evaluation of services

- Conduct controlled studies (multi-site randomized clinical trials) that evaluate the long-term effects of P-BRSS on recovery outcomes.
- Conduct cost studies on the ability of P-BRSS to reduce hospitalization and arrest/incarceration rates, reduce the number and duration of addiction treatment episodes and generate measurable recovery capital (e.g., employment).
- Conduct qualitative evaluations of the impact of P-BRSS on indigenous recovery support structures and the larger community.
- Evaluate the impact of organizational setting (peer-founded and controlled organization, peer employees as a component of addiction treatment or other community organization); funding scheme (government funding versus private funding versus voluntary); role construction (recovery support services as specialized role versus a function within existing roles; paid versus volunteer recovery support specialists), and P-BRSS philosophy (medical, social, cultural, religious, liberationist) on the outcomes of peer-based services.

The current system of addiction treatment is in need of redesign and renewal. P-BRSS could become a superficial (token) appendage to this system or it could become an instrument that sparks a wider transformation of that system. P-BRSS could help shift the addiction treatment system from serial episodes of self-encapsulated acute care to a model of sustained recovery management. So typical of the many paradoxes of recovery, addiction treatment as a system of care might well be redeemed by those for whom it was originally designed to serve.

Acknowledgement: The views expressed here are my own, conveyed through my roles as a recovery historian and recovery advocate, and should not be interpreted as reflecting the policies or opinions of organizations with whom I have been associated or who have provided financial support for my work.

References and Recommended Reading

A.A. Guidelines for A.A. Members Employed in the Alcoholism Field. (ND). New York: General Service Office, Alcoholics Anonymous.

Anderson, D. (1944). The place of the lay therapist in the treatment of alcoholics. *Quarterly Journal of Studies on Alcohol*, September, 257-266.

Bissell, L. (1982). Recovered alcoholic counselors. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism.* New York: Gardner Press, pp. 810-817.

Blum, T. and Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors: A survey. *Journal of Health and Social Behavior*, 365-378.

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.* New York: Plenum Press, pp. 545-565.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456.

Borkman, T. (1997) Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment,* 15(1):37-42.

Brown, J.D. (1991) Preprofessional socialization and identity transformation: The case of the professional ex. *Journal of Contemporary Ethnography,* 20(2):157-178.

Connet, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, 15:585-589.

Coyhis, D. and White, W. (2003) Alcohol problems in Native America: Changing paradigms and

clinical practices. *Alcoholism Treatment Quarterly*, 3/4:157-165.
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, 339–352.
Durlak, J. (1979). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 86:80-92.
Else, J.D. (1999) Recovering recovery. *Journal of Ministry in Addiction & Recovery*. 6(2):11-23.
Galanter, M, Castaneda, R., and Salamon, I. (1987). Institutional self-help therapy for alcoholism: Clinical outcome. *Alcoholism: Clinical and Experimental Research*, 11(5):424-429.
Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction without Treatment.* New York: New York University Press.
Hattie, J.A., Sharpley, C.F., & Rogers, H.J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 95:534-541.
Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58, 231-238.
Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.
Janzen, R. (2001). *The Rise and Fall of Synanon*. Baltimore: Johns Hopkins University Press.
Jason, L.A. and Kobayashi, R.B. (1993) Community building: Our next frontier. *Journal of Primary Prevention,* 15:195-208.
Jason, L.A., Davis, M.I., Ferrari, J.R. And Bishop, P. D. (2001) Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education,* 31(1):1-27.
Kahn, M. and Fua, C. (1992). Counselor training as a treatment for alcoholism: The helper principle in action. *The International Journal of Social Psychiatry*, 38(3), 208-214.
Kinney, J. (1983). Relapse among alcoholics who are alcoholism counselors. *Journal of Studies on Alcohol,* 44(4): 744-748.
McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In: Staub, G. and Kent, L. *The Para-Professional in the Treatment of Alcoholism*. Springfield: IL: Charles C. Thomas Publisher, pp. 91-105.
McKnight, J. (1995). *The Careless Society: Community and its Counterfeits*. New York: Basic Books.
McLellan, A.T., Lewis, D.C., O'Brien, C.P, and Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association* 284(13), 1689-1695.
Miller, W. and Kurtz, E. (1994). Models of alcoholism used in treatment: Contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol*, March, 159-166.
Miller, W. R., & C'de Baca, J. (2001). *Quantum Change*. New York: Guilford.
Nealon-Woods, M, Ferrari, J., and Jason, L. (1995). Twelve-Step program use among Oxford House residents: Spirituality or social support for sobriety? *Journal of Substance Abuse,* 7:311-318.
Office of Applied Studies (2001). *Treatment Episode Data Set (TEDS) 1994-1999: National Admissions to Substance Abuse Treatment Services*. DASIS Series S14, DHHS Publication No. (SMA)01-3550. Rockville, Maryland.
Ottenberg, D. (1977) Traditional and nontraditional credentials in addictive problems: A dispatch from the battlefield. *The Addiction Therapist,* 2(1):56-63.
Riessman, F. (1965). The "helper-therapy" principle. *Social Work,* 10, 24-32.
Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990s. *American Journal of Community Psychology,* 18, 221-230.

Rosenberg, C. (1982). The para-professional in alcoholism treatment. In: Pattison, E. and Kaufman, E. Eds., *Encyclopedic Handbook of Alcoholism*. New York: Gardner Press, pp. 802-809.

Sanders, M. (2002). The response of African American communities to addiction: An opportunity for treatment providers. *Alcoholism Treatment Quarterly,* 20(3/4), 167-174.

White, W. (1979). *Relapse as a Phenomenon of Staff Burnout in Recovering Substance Abusers Working as Counselors*. Rockville, MD: HCS, Inc.

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

White, W. (1997). *The Incestuous Workplace*. Center City, MN: Hazelden.

White, W. (1998) *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000a) The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly,* 18(1), 1-23.

White, W. (2000b). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly,* 18(2), 1-25.

White, W. (2000c). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases, 19*(2), 1-10.

White, W. (2000d). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at CSAT Recovery Community Support Program (RCSP) Conference, Washington, D.C. Posted at www.bhrm.org

White, W. (2001a). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly,* 19(1), 1-22.

White, W. (2001b). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly,* 19(4), 1-32.

White, W. (2001c). Recovery university: The campus as a recovering community. *Student Assistance Journal, 13*(2), 24-26.

White, W. (2002a) An Addiction Recovery Glossary: The Languages of American Communities of Recovery. www.bhrm.org and www.efavor.org.

White, W. (2002b) *Toward a vision of peer-driven and peer-led recovery support services*. Presented at Recovery Community Support Program Conference, July 23, 2002, Washington D.C..

White, W. (2003a). The road not taken: The lost roots of addiction counseling. *Counselor, 4*(2), 22-23.

White, W. (2003b). A history of contempt: Countertransference and the dangers of service integration. *Counselor,* 4(6):20-23.

White, W. (in press). Addiction recovery mutual aid societies: An enduring international phenomenon. *Addiction*.

White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly,* 20(3/4):107-130.

White, W., Boyle, M. and Loveland, D. (2003) Recovery Management: Transcending the Limitations of Addiction Treatment. *Behavioral Health Management* 23(3):38-44. (http://www.behavioral.net/2003_05-06/featurearticle.ht).

White, W., Boyle, M., & Loveland, D. (in press). Recovery from addiction and recovery from mental illness: Shared and contrasting lessons. In R. Ralph & P. Corrigan (Eds.), *Recovery and mental illness: Consumer visions and research paradigms*. Washington DC: American Psychological Association.

White, W. L. & Godley, M. D. (2003). The history and future of “aftercare”. *Counselor Magazine, 4(1)*, 19-21.

White, W. and Popovits, R. (2002). *Critical Incidents: Ethical Issues in the Prevention and Treatment of Addiction*. Bloomington, IL: Chestnut Health Systems.

White, W. & Sanders, M. (forthcoming). Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities.
Williams, C. with Laird, R. (1992). *No Hiding Place: Empowerment and Recovery for Troubled Communities*. New York, NY: Harper San Francisco.
Wilson, D. (1984). Impaired counselor: The ignored problem of the new profession. *Counselor*, July/August, p. 5.



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) Recovery rising: Radical recovery in America. Posted at **http://www.bhrm.org** and **http://www.facesandvoicesofrecovery.org**

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, pp. 121-134. Posted at **www.williamwhitepapers.com**

Recovery rising: Radical recovery in America

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

. . 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. – from The Red Road to Wellbriety, 2002

In the mid-eighteenth century a number of Delaware Prophets launched the first Native American abstinence-based religious and cultural revitalization movements among native peoples. Today, a vibrant Wellbriety movement is spreading through Indian country under the sober leadership of Native Americans who are using their own personal transformations as a springboard for the transformation and renewal of Native families and tribes.

In 1845 Frederick Douglass signed a pledge of abstinence and went on to lead the movement to abolish slavery in America. Douglass also played a critical role in the "colored temperance movement" via his assertion that the sobriety of black people was essential to their liberation and assumption of full citizenship. Today, African Americans in recovery and their family members are again moving beyond their own healing to confront the larger alcohol and drug problems of their communities. They are organizing within their churches and creating new grassroots recovery advocacy and social-action organizations.

The American temperance movement was fueled in great part by women whose lives had been wounded by the alcoholism of their fathers, brothers, husbands, and sons. Their sustained activism played a major role in reducing American alcohol problems over the course of the nineteenth century. Today, women and men whose families have been injured by alcohol and other drugs are once again organizing to change social policies related to these problems.

In the mid-nineteenth century members of the Washingtonian Temperance Society opened a "Home for the Fallen"—the

precursor to the Washingtonian Homes of Boston and Chicago that were among the earliest addiction-treatment programs in the country. Today, people in recovery are organizing an ever-expanding network of sober houses and recovery homes to once again provide a sober environment for those seeking recovery.

In the nineteenth century charismatic speakers such as John Gough and John Hawkins sparked hope among the addicted through their powerful stories of recovery from addiction. Today, speakers with similar stories and charisma are replicating this process by calling for social as well as personal change.

Something is reawakening inside America. People whose stigmatized condition left them hiding alone or cloistered in subterranean subcultures are stepping into the light to tell the stories of their wounds and their redemption. They are offering their time, talents, and testimonies to address alcohol and other drug-related problems in their local communities and in the country as a whole. They exemplify a transition from self-healing to social activism that could aptly be described as a style of radical recovery.

For the past five years I have had the opportunity to observe and collaborate with these recovery activists from across the country. The purpose of this brief essay is to honor the spirit of these activists by describing their unique style of recovery.

The coupling of the two words—radical and recovery—seems incongruous. While addiction connotes excess, recovery is rooted in the cultivation of balance and harmony. To do anything to an extreme would seem more a symptom of addiction than a dimension of recovery. But some aspects of the recovery process capitalize on this propensity for excess. The first edition of the book Alcoholics Anonymous speaks of the need for extreme measures to recover from alcoholism ("half measures availed us nothing"; AA, 1939); Women for Sobriety extols the importance of the "big decision" (Kirkpatrick, 1986); and Secular Organizations for Sobriety emphasizes the "sobriety priority"—a decision to never drink no matter what (Christopher, 1992). Many spiritual, religious, and secular recovery traditions share a radical commitment to sobriety and a radical reconstruction of personal identity and lifestyle. Recovery in these traditions is so extreme in its effects that it has come to be defined as far more than the removal of alcohol and other drugs from an otherwise unchanged life. The discovery that people seeking recovery could achieve together what had been unobtainable alone was itself a radical innovation. Put simply, personal recovery is often radical in its methods and outcomes. This essay explores a different kind of radicalness—a radicalness directed not at healing of the self, but at healing the world.

The development and resolution of alcohol and other drug (AOD) problems are usually understood on an individual level. Recovery narratives depict the evolution of the addiction experience, the transforming journey from addiction to recovery, and one's evolving life in recovery in highly personal terms. There are, however, larger contexts within which these personal addiction and recovery narratives can be understood. The sources and solutions to AOD problems are nested within particular historical, economic, political, and cultural contexts. In the aggregate, addiction transcends personal tragedy to stand as a symptom of system malfunction—a breakdown in the relationships between individuals, families, and communities. An understanding of the ecology of addiction and recovery constitutes the very foundation of radical recovery. *Radical recovery* is not a projection of blame for one's addiction, nor an abdication of personal responsibility for one's own recovery. It is a sustained meditation on the broader social meaning of the experiences of addiction and recovery.

Radical recovery is the use of one's recovery from addiction as a platform to advocate social change related to the sources of and solutions to community-wide AOD problems. The phrase radical recovery is not this author's invention. The call for a radicalized style of recovery emerged as a

reaction to the highly commercialized New Age recovery movement of the 1980s (Rapping, 1993; Morell, 1996), but its roots go much deeper. Radical recovery traditions span the prophetic leaders of eighteenth and nineteenth century Native American healing and cultural revitalization movements (Coyhis and White, 2002, 2003; Brave Heart, 2003), the "reformed reformers" of the American temperance movement (White, 1998), African American activists portraying drugs as a weapon of colonization (Tabor, 1970), and feminist charges of the 1990s that the concept of "codependency" mislabeled the cultural oppression of women as a problem of personal pathology (Tarvis, 1992; Kasl, 1992; also see Helmer, 1975, and Morgan, 1983). Today, radical recovery is exemplified in the lives of the men and women who are at the forefront of the New Recovery Advocacy Movement. This movement is reflected in new grassroots recovery-advocacy organizations whose collective goals are to

- ✓ portray alcoholism and addictions as problems for which there are viable and varied recovery solutions,
- ✓ provide living role-models that illustrate the diversity of those recovery solutions,
- ✓ counter public attempts to dehumanize, objectify, and demonize those with AOD problems,
- ✓ enhance the variety, availability, and quality of local/regional treatment and recovery support services, and
- ✓ remove environmental barriers to recovery, including the promotion of laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems (White, 2000).

Radical recovery is the discovery that changing oneself and changing the world are synergistic. It is choosing to become the dropped pebble that generates enduring and far-reaching ripples through one's family, community, and world. It is joining with kindred spirits to form communities of recovery that wish to amplify the influence of those ripples. Put simply, radical recovery is about people in recovery defining themselves as a community; moving beyond self-healing toward social action on issues related to their shared experience; reflecting on the needs of people still suffering from addiction; and forging goals and strategies to widen the doorways of entry into recovery and to enhance the quality of the recovery experience. Radical recovery is making amends and expressing gratitude through the vehicle of social action. It is mobilizing communities of recovery to build relationships of influence with other community institutions. It is a vision to reshape the ecology of addiction and recovery in America.

Where possible, radical recovery is family oriented—it is an extension of family healing. It recognizes the far-reaching effects of addiction on the family and conveys the good news that recovery is also far-reaching in its effects. Radical recovery is turning the healing power of recovery within families outward as an act of service to the world. Family members, "friends of recovery," and visionary professionals are joining with those who no longer suffer severe AOD problems to make important contributions to this emerging social-change movement.

Radical recovery is visible and vocal (in offering oneself as living proof of the reality of recovery). Such visibility is not about narcissism or exhibitionism (an assertion of ego). Radical recovery is not a superior style of recovery; it is one of many styles of recovery—a style open to those temperamentally suited for it and whose life circumstances allow such visibility without stigma-related injury to self or others. It is not an impulsive or reckless disclosure of one's addiction/recovery story. It is a context-appropriate report of one's status as a person who has achieved, or is working to achieve, sustained recovery from addiction. It is strategically using one's personal/family/neighborhood story to inform a broader policy debate. It is the willingness to add one's own face and voice to other visible faces and voices of recovery.

Radical recovery recognizes that visibility and voice come at a price within a

society that continues to stigmatize those linked to AOD problems. It seeks only a vanguard of recovered and recovering people whose personal circumstances allow them to stand as living proof of the proposition that recovery is a reality for millions of people around the world. It is the use of the personal testimonies of that vanguard to convey hope to individuals, families, and communities. It is the recognition that recovery is a gift bringing duties and obligations that transcend the self. But radical recovery, like most styles of recovery, is filled with paradoxes. Speaking out is as much about asking questions (provoking critical reflection) as it is about making statements. Speaking out has power only after silencing the self through acts of self-reflection and listening. Standing as a witness has power only when standing is an act of service, not when standing is self-congratulation.

Radical recovery is not an invitation to violate the anonymity traditions of Alcoholics Anonymous, Narcotics Anonymous, and other twelve-step fellowships. It is an invitation for some individuals and family members in twelve-step recovery and those from other pathways of recovery to talk publicly about their recovery status without reference to the means by which that recovery was achieved, e.g., without specific references to AA/NA affiliation at the level of press. It is an invitation for people to become a messenger of recovery apart from their particular identities as members of AA, NA, CA, WFS, WFS, SOS, LSR, or other recovery societies.

Radical recovery is focused. It extends the singularity of purpose of recovery mutual-aid groups into the arena of social action by remaining focused on issues linked to addiction and recovery. Radical recovery avoids diversions. In the current wave of service integration initiatives, radical recovery brings a singular voice of advocacy for the needs of those suffering from addiction and the needs of those in recovery. Radical recovery stays "on message." Radical Recovery is solution focused. It is about more than being a critic; it is about being a positive, creative force within local communities and the larger culture. It does not talk about personal, family, or community pathology without noting the presence of personal, family, and community resilience. It is more concerned with the details of solutions than the details of problems.

*Radical recovery brings a sense of urg*ency. Its celebration of recovery is tempered by its awareness that people continue to live deformed lives, languish in physical and psychological prisons, and needlessly die because they have not yet found the entrance to recovery. At the same time, radical recovery is patient in its recognition that community change, like personal change, requires time and sustained effort. Radical recovery is bold, but its boldness flows from integrity rather than recklessness. It is grounded in stillness, reflection, questioning, and listening.

Radical recovery is confrontive (of the social conditions and institutional interests within which AOD problems arise and flourish). It confronts the social stigma that shrouds addiction and inhibits recovery. One of the more astute criticisms of the modern recovery movement is that positing the source of and solution to AOD problems within the vulnerability and resilience of the individual ignores environmental conditions within which such problems flourish and strategies through which they could be prevented or resolved. While service work with individuals still suffering from addiction has a long tradition within American communities of recovery, only rarely have recovered and recovering people taken collective action on broader political and social concerns. There is, however, growing evidence that people in recovery are involving themselves in community service as part of their recovery process (Kurtz & Fisher, 2003). A new recovery-advocacy movement is mobilizing communities of recovery into a force for political advocacy on AOD-related issues (White, 2000). Radical recovery is stepping forward to be part of this movement.

Radical recovery is political (in recognizing that social change involves the acquisition and strategic use of power to shape addiction/recovery promoting and

inhibiting forces). It recognizes that recovery itself can be a political act as well as a means of personal healing and redemption. It is a willingness to join together for collective action on issues related to addiction and recovery. It is self-identified Democrats, Republicans, and independents joining together for common cause within the proclamation that AOD problems so threaten the health of this country that their resolution must transcend partisan politics.

Radical recovery is sensitive to institutional interests. Radical recovery is a sustained reflection on the sociopolitical and economic influences that influence AOD problems and policies. Radical recovery recognizes the existence of predatory industries that promote and profit from addictive products (see the work of Dr. Jean Kilbourne). When those with AOD problems are sequestered in ever-increasing numbers in jails and prisons, radical recovery asks: what individuals and institutions profit from such circumstances? It openly confronts the ways in which public health can be sacrificed for corporate gain. Radical recovery is the recognition that young men and women of color and disenfranchised whites have become the raw materials that feed the institutional (prison) economies of many communities. Radical recovery is willing to confront treatment professionals and treatment institutions that view people with AOD problems as a crop to be harvested for personal and institutional profit. Radical recovery is willing to expose hustlers masked as healers. Generations of volunteers within the local affiliates of the National Council on Alcoholism and Drug Dependence laid the policy and legislative foundations for the modern system of addiction treatment. Today's advocates are lobbying to protect that infrastructure, but they are also calling upon today's treatment organizations to become more accountable to the needs of the individuals, families, and communities they serve. *Radical recovery respects the importance of professional resources but emphasizes the recovery-initiating and recovery sustaining power of relationships that are natural (as opposed to professionalized), reciprocal (as opposed to hierarchical), and enduring (as opposed to transient).* Radical recovery is not about lobbying for an infinite number of ever-expanding addiction treatment centers. It is about nurturing the development of indigenous recovery-support resources that diminish the need for professionally directed treatment.

Radical recovery is inclusive (in its tolerance and celebration of the multiple pathways and innumerable varieties of recovery experience) and respectful (of the traditions and folkways of various communities of recovery). Radical recovery frees one from the need to have the single recovery answer and allows one to celebrate the diverse pathways that foster escape from the addiction quagmire. It allows one to respond to such differences not out of defensive criticalness but out of true joy for another's freedom. Radical recovery makes no claim other than one's own experience and is not threatened by experiences that are different. It affirms choice in recovery and celebrates the diversity of those choices. Stated simply, its motto is "recovery by any means necessary." Radical recovery also recognizes that shared pain and redemption are the foundation of communities of recovery and that such kinship of suffering and rebirth transcends the boundaries of gender, race, social class, developmental age, sexual orientation, religious beliefs, and political affiliation. It seeks to extend the influence of those relational communities outward into the world.

Radical recovery promotes metaphors of personal and community liberation for historically disempowered peoples. There are powerful metaphors that convey the sources and solutions to AOD problems in ways that catalyze personal and community action. Radical recovery elicits such metaphors from the collective stories of those suffering from addiction within particular community, historical, and cultural contexts and respects the right of communities to generate their own catalytic metaphors. Radical recovery respects the power of such metaphors as "disease," "surrender," and "acceptance" in one cultural context and the power of "genocide,"

"liberation," and "resurrection" in others. Radical recovery is about using the raw materials of addiction and healing to rebuild and revitalize families, neighborhoods, and communities. It is about recognizing the healing power of a community of shared experience embraced by larger communities of hope and encouragement.

Radical recovery is collaborative. It embraces coalitions of people with shared interests and aspirations involved in kindred causes. The movement within which radical recovery is embraced is interracial and interfaith and brings together people from diverse social classes and personal and professional backgrounds who otherwise share little in common.

Pitfalls of Radical Recovery

A radical style of recovery is not without its pitfalls. History bears witness to a number of important lessons related to personal recovery and participation in social change.

Radical recovery is a philosophy of social action; it is not a program of personal recovery. The history of recovery is strewn with the bodies of those who thought that they could get and stay sober by trying to change the world. Radical recovery is not a means of achieving or sustaining personal recovery: it is one possible fruit of such recovery. Participation in social change must not obscure the primacy of personal recovery as a foundation for larger service to the community. It must not become a diversion from those daily activities that sustain and enrich personal recovery.

Collective efforts at social change are best conducted in affiliation with organizations whose mission is social change rather than through organizations whose primary purpose is mutual support for addiction recovery. Many mutual-aid organizations have lost touch with their primary mission when they have become involved in outside political and religious issues. Such involvements led to the demise of many pre-AA recovery mutual-aid societies and contributed to the emergence of the Twelve Traditions of Alcoholics Anonymous. The integrity of the firewall between mutual-aid and advocacy organizations and their respective activities must be protected.

Radical recovery, in its focus on social systems and social policies, could divert attention away from the suffering of individuals and families. Care will need to be taken that advocacy for social policies and programs does not weaken the face-to-face service to those still suffering from addiction. In focusing on all manner of contextual issues, it is easy to be seduced into forgetting the power of the drug. It is the drug that people become addicted to, and personal recovery can begin only at that starting point and then work back through the etiological influences on the person-drug relationship. Treatment and mutual-aid groups are designed to aid that process at a personal level. Advocacy organizations are designed to address the contexts in which addiction and recovery flourish. Neither is a replacement for the other.

Radical recovery could, in the name of serving communities of recovery, inadvertently lead to schisms within and between those communities. Organized recovery advocacy will raise potentially contentious questions: Who legitimately represents the needs and aspirations of people in recovery? How can diverse communities and individuals reach consensus on goals and strategies? How will disagreements be resolved or managed? What fractures could social action engender in personal and organizational relationships within communities of recovery? Conflict within the social action arena could injure relationships and affiliations within the recovery mutual-aid arena and further polarize the recovery community into ideological camps.

Social-change movements breed excesses and ignite counter-movements that, in turn, undermine the successes that have been achieved. For example, the industrialization and commercialization of addiction treatment in the 1980s led to a financial and ideological backlash that dramatically altered the image and availability of addiction treatment in the

United States and increased therapeutic pessimism about the prospects of long-term recovery. Great care must be taken in the selection of the core ideas and methods that flow from this style of radical recovery.

Social-change movements go through predictable stages and are prone to burn themselves out. For some, radical recovery will mark a brief period of intense, time-limited activity in their lives. For others, radical recovery will be a life-enduring marathon; it will come to be understood as part of the central meaning of one's life. Successful social movements need both styles of involvement.

Recovery Rising

A radical recovery movement is now rising in America. That movement is flowing from the realization that addiction and its progeny of problems are visible everywhere, while recovery from addiction lies hidden. It is rising in the recognition that the stigma attached to AOD problems has increased in recent decades and has fueled the demedicalization and recriminalization of these problems. What started out as "zero tolerance" for drugs rapidly evolved into zero tolerance for people with AOD-related problems. It is in this regressive climate that a style of recovery is emerging that is radical in its scope (focus on environmental as well as person al transformation), radical in its inclusiveness (celebration of multiple pathways and styles of recovery), and radical in its synthesis of social responsibility and personal accountability. People in recovery are looking beyond their own addiction and recovery experiences to the broader social conditions within which AOD problems arise and are sustained. A radicalized vanguard of people in recovery is using personal transformation as a fulcrum for social change. They are living Gandhi's challenge to become the change they wish to see in the world. Those who were once part of the problem are becoming part of the solution.

Prophetic voices are rising from communities of recovery across America. Voices of the formerly hopeless are becoming instruments of personal healing and community renewal and redemption. If you share this call to a larger platform of service and believe that your personal/family story can touch others, come join us. Become part of this movement.

Acknowledgement: I would like to thank the following individuals for their encouragement, feedback, and suggestions on this paper: Ben Bass, Alex Brumbaugh, Don Coyhis, Mark Sanders, Bob Savage, Jason Schwartz, Richard Simonelli, Pat Taylor, Phil Valentine and Pam Woll.

References

Alcoholics Anonymous: *The Story of How More than One Hundred Men Have Recovered from Alcoholism*. (1939). NY: Works Publishing Company.

Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: a Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7-13.

Christopher, J. (1992). *SOS Sobriety: The Proven Alternative to 12-step Programs*. Buffalo, NY: Prometheus.

Coyhis, D., & White, W. (2002). Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor*, 3(5), 16-20.

Coyhis, D., & White, W. (2003) Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly*, 3/4, 157-165.

Helmer, J. (1975). *Drugs and Minority Oppression*. New York: Seabury.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life*. New York:
Ballantine.

Kurtz, L. F., & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems*, 30, 875-904.

Morell, C. (1996). Radicalizing recovery: Addiction, spirituality, and politics. *Social Work*, 41(3), 306-312.

Morgan, P. (1983). Alcohol, disinhibition, and domination: A conceptual analysis. In Room, R., & Collins G. (Eds.), *Alcohol and Disinhibition: Nature and Meaning of the Link* (pp. 405-436). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Rapping, E. (1993, January). Needed: A radical recovery. *Progressive*, pp. 32-34.

The Red Road to Wellbriety. (2002). Colorado Springs, CO: White Bison.

Tabor, M. (1970). *Capitalism Plus Dope Equals Genocide*. Black Panther Party, U.S.A.

Tarvis, C. (1992). *The Mismeasure of Women*. NY: Simon & Schuster.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

White, W. (2000). Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy. Paper presented at the Recovery Community Support Program (RCSP) Conference, Washington, DC Posted at www.bhrm.org and www.facesandvoicesofrecovery.org.



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. & Taylor, P. (2006). A New Recovery Advocacy Movement. Posted at **www.facesandvoicesofrecovery.org**; posted at **www.williamwhitepapers.com**

A New Recovery Advocacy Movement

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

People in recovery from addiction, their families, friends and allies are on the move. Some are calling on mayors, governors and legislators to change policies to make it possible for people to get needed treatment and recovery support services. Others are joining National Alcohol and Drug Addiction Recovery Month celebrations that draw tens of thousands of people and extensive media coverage.

Local communities of recovery are organizing and sharing ideas, resources and experiences. A grass roots media campaign (see www.recoveryiseverywhere.org) is countering stigma and putting a positive face on recovery. A network of thousands of recovery homes is spreading rapidly to small towns and large cities. Recovery High Schools are flourishing, as are special programs for the growing number of recovering people entering or returning to college. Innovative peer-based recovery support services, ranging from Recovery Support Centers to growing networks of recovery coaches are testimony to new creative solutions to addiction. Something is happening in our communities -- a renewed spirit of service and activism that has been christened the New Recovery Advocacy Movement.

Faces & Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Legal Action Center, the Johnson Institute, the Center for Substance Abuse Treatment's Recovery Community Services Program grantees such as White Bison, Association of Persons Affected by Addiction (APAA) and Connecticut Community for Addiction Recovery (CCAR) and hundreds of new grassroots recovery community organizations are all part of this exciting movement. Recovering people are collaborating with visionary professionals to communicate to the world that addiction recovery is a reality for millions of people and their families. This movement is calling for a vanguard of recovering people and their families and friends to stand together as living proof of this proposition.

Individual recovery advocates and recovery community organizations are pursuing several core strategies within this movement. They include:

- *Building strong, grassroots organizations* that develop recovery leaders, offer opportunities for recovering people to express their collective voice and provide a forum for community service.
- *Advocating for meaningful representation and voice* for people in recovery and their family members on issues that affect their lives.
- *Assessing needs* related to the adequacy and quality of local treatment and recovery support services.
- *Educating the public, policymakers and service providers* about the prevalence and pathways of addiction recovery.
- *Developing human and fiscal resources* by expanding philanthropic and public support for addiction treatment, recovery support services and recovery advocacy and cultivating volunteerism within local communities of recovery.
- *Advocating for policy changes* at the local, state and federal levels that promote recovery and remove barriers to recovery.
- *Celebrating recovery from addiction* through public events that offer living testimony of the transformative power of recovery.
- *Supporting research* that illuminates effective strategies and the processes of long-term recovery.

If you want to know more about or be part of this growing movement, contact the national Faces & Voices of Recovery campaign at www.facesandvoicesofrecovery.org.

Since its inception, this column has described the history of recovery in America. Come join us today in shaping the future of recovery in America.

William White (bwhite@chestnut.org) is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Pat Taylor (pat.taylor@verizon.net) is the Executive Director of Faces & Voices of Recovery.

Source:
www.facesandvoicesofrecovery.org/pdf/White%20Publications/ANewRecoveryAdvocacyMovement.pdf



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). Recovery advocacy is not a recovery program. Recover Magazine, 5(1), 18; 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, pp77-78. Posted at **www.williamwhitepapers.com**

HISTORY CORNER
Recovery Advocacy Is Not a Recovery Program

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

I recently received the heart-rending news that a person prominently involved in many recovery advocacy efforts had relapsed and died of an overdose. It reminded me once again that personal recovery is the foundation of all larger efforts to educate, advocate or counsel in the alcohol and other drug problems arena.

This is not a new lesson. Consider, for example, the following stories. John Gough got sober in the Washingtonian revival of the early 1840s, but relapsed three times in the early period of his long career as America's most charismatic temperance reformer. The lawyer Edward Uniac always stated that he was more vulnerable to the call of alcohol during extended periods of rest than when he was moving from town to town giving his temperance lectures. But Uniac suffered repeated relapses and died in 1869 of an overdose of whiskey and opium while on a temperance lecture tour in Massachusetts. Luther Benson tried to use his own personal struggles with alcohol in the temperance lectures he gave across the country. His tails of continued relapses while on the lecture circuit were penned while he was residing in the Indiana Asylum for the Insane. His 1896 autobiography was entitled Fifteen Years in Hell. Benson truly believed that throwing himself into temperance work could quell his own appetite for alcohol. In retrospect, he was forced to admit the following:

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.

The stories of Gough, Uniac, and Benson are not unique. Similar tales were told by others who sought to cure themselves on the temperance lecture circuit. This is not to imply that there were not recovering people who got sober and stayed sober working in the 19th century temperance movement and treatment institutions. But it does underscore an important lesson that emerged out of the

19th century recovery movements. That lesson is that service activity, by itself, does not constitute a solid program for continued sobriety. This same lesson was relearned throughout the 20th century, particularly within the modern addiction counselor movement.

A New Recovery Advocacy Movement is spreading across America leaving in its wake new grassroots recovery advocacy organizations and a fresh generation of recovering people and their families seeking new ways to carry a message of hope to those still suffering. To prepare themselves, this new generation would do well to review the stories of old.

The enduring message in all of these stories is clear: Working as an addictions educator, advocate, or counselor does not constitute a program of personal recovery. Those who forget that lesson court injury to themselves and to the very movements to which they claim allegiance. The primacy of personal recovery cannot be forgotten.



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. & Hagen, R. (2005). Treatment, recovery, community: A call for reconnection. *Counselor*, 6(6), 52-56. Posted at www.williamwhitepapers.com

Treatment, Recovery, Community: A Call for Reconnection

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The relationship between treatment agencies and the local communities in which they are nested has undergone significant changes over the past forty years. This essay reviews the nature of these changes and calls for a renewal of the linkage between treatment, recovery and community.

Interconnectedness of Treatment and Community

During the 1960s and 1970s, many factors contributed to a close relationship between newly birthed addiction treatment organizations and the local communities they served. Many of the citizen advocates who had volunteered in the local alcoholism and drug abuse councils that preceded the formal opening of local treatment organizations migrated into board and staff positions within these new agencies. This historical continuity exerted pressure to remain faithful to the founding vision of recovery-focused service interventions. Such accountability was further enhanced by the fact that local funding—dollars directly allocated from county or township boards and city councils, local contributions of goods and services and local donation of dollars--constituted an important portion of the budgets of early programs. The power of local communities was further enhanced by their review, comment and, in some cases, approval authority for all federal and state requests for funds to provide addiction treatment services. In some parts of the country, local counties, townships and cities were the actual recipient of treatment dollars that were then allocated to one or more not-for-profit treatment service providers.

The emerging service systems prioritized their ultimate loyalty as follows: 1) individuals and families in need of treatment services, 2) local community institutions, e.g., the criminal justice system, the health care system, allied human service agencies, and finally, 3) the growing funding and regulatory agencies overseeing addiction treatment. The struggle for legitimization of addiction treatment organizations (via licensure and accreditation) and addiction treatment personnel (via credentialing and certification) was initially focused on building professional credibility in the eyes of the field's most important consumers: local citizens and their families as well as local service institutions.

There was a similarly close relationship between many early treatment programs and local recovery mutual aid societies, particularly

Alcoholics Anonymous and Al-Anon. Many programs relied on a large cadre of AA and Al-Anon volunteers, met regularly with Hospital and Institutions Committees of AA, worked closely with AA sponsors, recruited staff from within the local recovery network, and expected staff (those with and without recovery backgrounds) to participate in the meetings of the local recovery community. Many budding treatment programs served as a hub of the local recovery community, with community rooms of treatment programs providing local people in recovery opportunities for fellowship and service. This close relationship between professional and indigenous recovery support organizations was not without its problems, but these were generally resolved through a growing folklore carried by the elders of these respective but overlapping communities.

This high level of interaction with the local community infused early addiction professionals with a detailed knowledge of indigenous sources of recovery support, kept staff closely linked to local service agencies and kept staff linked to the lives of their clients following primary treatment. The latter was particularly important in connecting the process of treatment intervention to the larger and more enduring process of long-term recovery. What staff of this era lacked in technical skill was made up for by their deep understanding of the healing, transformative power of participation in a community of shared experience, strength and hope. An organizing vision of early programs was to bring recovery within the very heart of local institutions (jails, hospitals, businesses, schools, community centers, churches, social service agencies) in a way that would amplify this healing power of the community.

The earliest role of counselor was not one of psychotherapeutic healing but a guide who led those wounded by alcohol and other drugs into participation with local communities of recovery whose supportive relationships were equal, reciprocal, enduring and non-commercialized. Many early addiction service organizations of the 1960s and 1970s developed a unique blend of clinical, community development and community organization models of intervention. Within these hybrid models, addiction treatment agencies were not the first line of defense in response to alcohol and other drug problems; they were the final safety net to help the community address those most severe and complex problems that could not be resolved through natural resources. However the solution even to these most severe problems emphasized the power of community (Mulford, 1976; White, 2002, 2003).

The Forces of Disconnection

In most parts of the United States, the connection between treatment, recovery and community peaked in the late 1970s and 1980s and then faded throughout the 1980s and 1990s. Several factors contributed to this disconnection process.

Aging of the Modern Alcoholism Movement: The leaders of the modern alcoholism movement spent lifetimes laying the foundation for a national network of addiction treatment programs. As these pioneers aged throughout the 1970s and 1980s, their representation on boards of treatment organizations diminished. The new board member of this era brought, not a history of recovery advocacy, but the political, economic, managerial and legal acumen to guide grassroots service agencies into maturity as formal organizations. As treatment agencies grew up (achieved professional autonomy), there was a tendency to separate themselves from the community-based social movements from whence they came.

Professionalization of Addiction Counseling: Efforts to move the addiction counselor from the role of “paraprofessional” to a legitimate service professional propelled counselor credentialing, certification and licensure movements. These movements elevated the knowledge and skill base of addiction counseling but inadvertently weakened the perceived role of community in recovery. Counselor training programs espoused “biopsychosocial” philosophies but were focused primarily on clinical models of intervention that paid little attention to the physical and cultural ecology of addiction and recovery. The community alcoholism consultant gave way to the counselor as a specialized addiction psychotherapist. At the same time, new ethical and clinical guidelines discouraged counselors from self-disclosing their own recovery status/story and cautioned counselors about “dual relationship” problems that could

arise in their professional/peer relationships. The elevation of the role of addiction counselor separated the counselor from the client and the treatment agency from both local communities of recovery and the larger civilian communities.

Confidentiality and Privacy: The stigma attached to alcohol and other drug problems was so great in the mid-twentieth century that the addictions field posited confidentiality and privacy assurances as a requirement for effective treatment. The resulting federal and state regulations and ethical codes generated the most restrictive confidentiality assurances in the history of health care. The increased professionalization of the treatment environment and tightening regulations related to confidentiality ended the previously open door policies through which many treatment facilities had served as drop-in centers for local people in recovery. These same factors contributed to the demise of once vibrant volunteer programs that had served to guide clients into relationships with local communities of recovery.

Industrialization of Addiction Treatment: What credentialing did for the addictions counselor, program licensure and accreditation did for the addictions treatment agency. The vision of the fledgling programs of the early 1970s was that accreditation (through the Joint Commission on Accreditation of Hospitals) would bring institutional credibility and open the flow of insurance money to support addiction treatment. We became obsessed with regulatory compliance and inadvertently elevated accountability to regulatory agencies over accountability to our clients and communities. What had in its infancy been a world focused on clients and local community need quickly became a complex world of federal and state agencies, accreditation bodies, and state and national professional associations. The treatment field, birthed as an adjunct to local communities of recovery, had become a bona fide industry.

Funding Influences: The weakening connection with local communities accelerated under the influence of changing patterns of funding for addiction treatment. As federal and state funding and third party insurance came to dwarf local contributions, addiction treatment agencies shifted their energies to responding to the demands of these external entities and away from maintaining close working relationships with local communities. Many local communities who at one time had approval power over the allocation of treatment dollars lost this authority as many states centralized funding decisions in the state bureaucracy. Local communities in most areas even lost their perfunctory review and comment role in such funding.

Changing Organizational Identity: Sometime in the 1980s, addiction treatment programs stopped being “community-based social service agencies” and became “behavioral health care businesses.” For too many organizations, accountability within this new business orientation was measured, not by fidelity to one’s founding vision or local service responsiveness, but by the organization’s financial profits or losses. In this climate, a program director was less likely to be asked about the recovery rate of his or her program than about the census or the profit margin of that program. This business and profit orientation has now reached such a state of excess that the non-profit status of some addiction treatment organizations could be legally challenged. In the for-profit addiction treatment community, little motivation exists to respond to local community needs as few of the patients entering these facilities come from these communities.

When the financial backlash of the late 1980s and early 1990s led to the closing of many residential and inpatient programs, many of the surviving programs expanded their geographical service areas. Such expansion weakened the influence of the local communities in which these organizations were located. For example, Chestnut Health Systems has gone from a handful of staff serving one county in 1973 to an organization that today has more than 600 employees providing services around the world—a transformation that has us pondering how precisely we define community accountability.

The professionalization and industrialization of addiction treatment have inadvertently weakened the relationship between professionally-directed addiction treatment and the long-term processes of recovery as well as the linkage between these experiences and indigenous community institutions. The loss of our founding leaders and their guiding vision has also contributed to this process of disconnection.

Back to the Future: A Call for Reconnection

There are many emerging forces that will push addiction treatment organizations to rebuild community relationships.

The New Recovery Advocacy Movement: There is a growing grassroots recovery advocacy movement in the United States. These local grassroots organizations are holding local treatment providers to a higher level of accountability than has existed for decades. When recovery advocates and addiction treatment leaders join together, they envision a seamless connection between addiction treatment and the larger, more enduring, and more community-influenced process of addiction recovery.

Competition for Shrinking Resources: National, state and local economies combined with war-related expenditures and growing budget deficits are creating pressure to cut domestic programs. There will be growing competition for resources and struggles to achieve priority status in these circumstances. To position itself within this environment of increased vulnerability, the addictions field will need to rebuild its grassroots constituencies. Service arenas that can only defend themselves through the voices of those with financial interests in these institutions will not fare well in this environment. Priority status will go to those arenas that demonstrate strong community (as well as broad political) support for their continued funding.

Recovery Outcomes: Independent funders and brokers of behavioral health services will exert similar pressures for involvement in the community but for quite different reasons. There is growing evidence that long-term recovery outcomes are shaped as much, if not more by what happens after treatment as what happens during treatment. This evidence supports post-treatment monitoring, sustained recovery support services, assertive linkages to indigenous communities of recovery, and early re-intervention. Insurance companies and managed behavioral health care firms will exert pressure for strong community relationships simply because those relationships are a crucial predictor of long-term recovery outcomes and reductions in health care costs.

Implications for Addiction Professionals

So where does this push for reconnection with community leave us? It is time we added our own voice to calls for addiction professionals to move out of our closed professional and social worlds and vibrantly re-enter the lives of our local communities. We can become students of the growing variety of recovery support structures. We can become members of local recovery advocacy organizations. We can advocate within our own organizations for a renewed relationship to the multiple community constituents we serve. We can become more visible ambassadors of our field within these communities. We can serve as recovery witnesses to the larger culture, sharing stories at every opportunity about lives transformed by addiction treatment and recovery. We can try to reconnect treatment, recovery and community.

About the Authors: William White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Russell Hagen is The CEO of Chestnut Health Systems and a board member of the National Association of Addiction Treatment Providers.

References

Mulford, H. (1976). *Alcohol abuse and citizen action: The community counselor/consultant approach*. Presented at the Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependence, Toronto, Canada, June 20-25, 1976.

White, W. (2002) A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly,* 19(4), 1-32.

White, W. (2003) The road not taken: The lost roots of addiction counseling. *Counselor,* 4(2), 22-23.



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. & Hagen, R. (2005). Treatment, recovery, community: A call for reconnection. *Counselor*, 6(6), 52-56. Posted at www.williamwhitepapers.com

Treatment, Recovery, Community: A Call for Reconnection

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The relationship between treatment agencies and the local communities in which they are nested has undergone significant changes over the past forty years. This essay reviews the nature of these changes and calls for a renewal of the linkage between treatment, recovery and community.

Interconnectedness of Treatment and Community

During the 1960s and 1970s, many factors contributed to a close relationship between newly birthed addiction treatment organizations and the local communities they served. Many of the citizen advocates who had volunteered in the local alcoholism and drug abuse councils that preceded the formal opening of local treatment organizations migrated into board and staff positions within these new agencies. This historical continuity exerted pressure to remain faithful to the founding vision of recovery-focused service interventions. Such accountability was further enhanced by the fact that local funding—dollars directly allocated from county or township boards and city councils, local contributions of goods and services and local donation of dollars--constituted an important portion of the budgets of early programs. The power of local communities was further enhanced by their review, comment and, in some cases, approval authority for all federal and state requests for funds to provide addiction treatment services. In some parts of the country, local counties, townships and cities were the actual recipient of treatment dollars that were then allocated to one or more not-for-profit treatment service providers.

The emerging service systems prioritized their ultimate loyalty as follows: 1) individuals and families in need of treatment services, 2) local community institutions, e.g., the criminal justice system, the health care system, allied human service agencies, and finally, 3) the growing funding and regulatory agencies overseeing addiction treatment. The struggle for legitimization of addiction treatment organizations (via licensure and accreditation) and addiction treatment personnel (via credentialing and certification) was initially focused on building professional credibility in the eyes of the field's most important consumers: local citizens and their families as well as local service institutions.

There was a similarly close relationship between many early treatment programs and local recovery mutual aid societies, particularly

Alcoholics Anonymous and Al-Anon. Many programs relied on a large cadre of AA and Al-Anon volunteers, met regularly with Hospital and Institutions Committees of AA, worked closely with AA sponsors, recruited staff from within the local recovery network, and expected staff (those with and without recovery backgrounds) to participate in the meetings of the local recovery community. Many budding treatment programs served as a hub of the local recovery community, with community rooms of treatment programs providing local people in recovery opportunities for fellowship and service. This close relationship between professional and indigenous recovery support organizations was not without its problems, but these were generally resolved through a growing folklore carried by the elders of these respective but overlapping communities.

This high level of interaction with the local community infused early addiction professionals with a detailed knowledge of indigenous sources of recovery support, kept staff closely linked to local service agencies and kept staff linked to the lives of their clients following primary treatment. The latter was particularly important in connecting the process of treatment intervention to the larger and more enduring process of long-term recovery. What staff of this era lacked in technical skill was made up for by their deep understanding of the healing, transformative power of participation in a community of shared experience, strength and hope. An organizing vision of early programs was to bring recovery within the very heart of local institutions (jails, hospitals, businesses, schools, community centers, churches, social service agencies) in a way that would amplify this healing power of the community.

The earliest role of counselor was not one of psychotherapeutic healing but a guide who led those wounded by alcohol and other drugs into participation with local communities of recovery whose supportive relationships were equal, reciprocal, enduring and non-commercialized. Many early addiction service organizations of the 1960s and 1970s developed a unique blend of clinical, community development and community organization models of intervention. Within these hybrid models, addiction treatment agencies were not the first line of defense in response to alcohol and other drug problems; they were the final safety net to help the community address those most severe and complex problems that could not be resolved through natural resources. However the solution even to these most severe problems emphasized the power of community (Mulford, 1976; White, 2002, 2003).

The Forces of Disconnection

In most parts of the United States, the connection between treatment, recovery and community peaked in the late 1970s and 1980s and then faded throughout the 1980s and 1990s. Several factors contributed to this disconnection process.

Aging of the Modern Alcoholism Movement: The leaders of the modern alcoholism movement spent lifetimes laying the foundation for a national network of addiction treatment programs. As these pioneers aged throughout the 1970s and 1980s, their representation on boards of treatment organizations diminished. The new board member of this era brought, not a history of recovery advocacy, but the political, economic, managerial and legal acumen to guide grassroots service agencies into maturity as formal organizations. As treatment agencies grew up (achieved professional autonomy), there was a tendency to separate themselves from the community-based social movements from whence they came.

Professionalization of Addiction Counseling: Efforts to move the addiction counselor from the role of “paraprofessional” to a legitimate service professional propelled counselor credentialing, certification and licensure movements. These movements elevated the knowledge and skill base of addiction counseling but inadvertently weakened the perceived role of community in recovery. Counselor training programs espoused “biopsychosocial” philosophies but were focused primarily on clinical models of intervention that paid little attention to the physical and cultural ecology of addiction and recovery. The community alcoholism consultant gave way to the counselor as a specialized addiction psychotherapist. At the same time, new ethical and clinical guidelines discouraged counselors from self-disclosing their own recovery status/story and cautioned counselors about “dual relationship” problems that could

arise in their professional/peer relationships. The elevation of the role of addiction counselor separated the counselor from the client and the treatment agency from both local communities of recovery and the larger civilian communities.

Confidentiality and Privacy: The stigma attached to alcohol and other drug problems was so great in the mid-twentieth century that the addictions field posited confidentiality and privacy assurances as a requirement for effective treatment. The resulting federal and state regulations and ethical codes generated the most restrictive confidentiality assurances in the history of health care. The increased professionalization of the treatment environment and tightening regulations related to confidentiality ended the previously open door policies through which many treatment facilities had served as drop-in centers for local people in recovery. These same factors contributed to the demise of once vibrant volunteer programs that had served to guide clients into relationships with local communities of recovery.

Industrialization of Addiction Treatment: What credentialing did for the addictions counselor, program licensure and accreditation did for the addictions treatment agency. The vision of the fledgling programs of the early 1970s was that accreditation (through the Joint Commission on Accreditation of Hospitals) would bring institutional credibility and open the flow of insurance money to support addiction treatment. We became obsessed with regulatory compliance and inadvertently elevated accountability to regulatory agencies over accountability to our clients and communities. What had in its infancy been a world focused on clients and local community need quickly became a complex world of federal and state agencies, accreditation bodies, and state and national professional associations. The treatment field, birthed as an adjunct to local communities of recovery, had become a bona fide industry.

Funding Influences: The weakening connection with local communities accelerated under the influence of changing patterns of funding for addiction treatment. As federal and state funding and third party insurance came to dwarf local contributions, addiction treatment agencies shifted their energies to responding to the demands of these external entities and away from maintaining close working relationships with local communities. Many local communities who at one time had approval power over the allocation of treatment dollars lost this authority as many states centralized funding decisions in the state bureaucracy. Local communities in most areas even lost their perfunctory review and comment role in such funding.

Changing Organizational Identity: Sometime in the 1980s, addiction treatment programs stopped being “community-based social service agencies” and became “behavioral health care businesses.” For too many organizations, accountability within this new business orientation was measured, not by fidelity to one’s founding vision or local service responsiveness, but by the organization’s financial profits or losses. In this climate, a program director was less likely to be asked about the recovery rate of his or her program than about the census or the profit margin of that program. This business and profit orientation has now reached such a state of excess that the non-profit status of some addiction treatment organizations could be legally challenged. In the for-profit addiction treatment community, little motivation exists to respond to local community needs as few of the patients entering these facilities come from these communities.

When the financial backlash of the late 1980s and early 1990s led to the closing of many residential and inpatient programs, many of the surviving programs expanded their geographical service areas. Such expansion weakened the influence of the local communities in which these organizations were located. For example, Chestnut Health Systems has gone from a handful of staff serving one county in 1973 to an organization that today has more than 600 employees providing services around the world—a transformation that has us pondering how precisely we define community accountability.

The professionalization and industrialization of addiction treatment have inadvertently weakened the relationship between professionally-directed addiction treatment and the long-term processes of recovery as well as the linkage between these experiences and indigenous community institutions. The loss of our founding leaders and their guiding vision has also contributed to this process of disconnection.

Back to the Future: A Call for Reconnection

There are many emerging forces that will push addiction treatment organizations to rebuild community relationships.

The New Recovery Advocacy Movement: There is a growing grassroots recovery advocacy movement in the United States. These local grassroots organizations are holding local treatment providers to a higher level of accountability than has existed for decades. When recovery advocates and addiction treatment leaders join together, they envision a seamless connection between addiction treatment and the larger, more enduring, and more community-influenced process of addiction recovery.

Competition for Shrinking Resources: National, state and local economies combined with war-related expenditures and growing budget deficits are creating pressure to cut domestic programs. There will be growing competition for resources and struggles to achieve priority status in these circumstances. To position itself within this environment of increased vulnerability, the addictions field will need to rebuild its grassroots constituencies. Service arenas that can only defend themselves through the voices of those with financial interests in these institutions will not fare well in this environment. Priority status will go to those arenas that demonstrate strong community (as well as broad political) support for their continued funding.

Recovery Outcomes: Independent funders and brokers of behavioral health services will exert similar pressures for involvement in the community but for quite different reasons. There is growing evidence that long-term recovery outcomes are shaped as much, if not more by what happens after treatment as what happens during treatment. This evidence supports post-treatment monitoring, sustained recovery support services, assertive linkages to indigenous communities of recovery, and early re-intervention. Insurance companies and managed behavioral health care firms will exert pressure for strong community relationships simply because those relationships are a crucial predictor of long-term recovery outcomes and reductions in health care costs.

Implications for Addiction Professionals

So where does this push for reconnection with community leave us? It is time we added our own voice to calls for addiction professionals to move out of our closed professional and social worlds and vibrantly re-enter the lives of our local communities. We can become students of the growing variety of recovery support structures. We can become members of local recovery advocacy organizations. We can advocate within our own organizations for a renewed relationship to the multiple community constituents we serve. We can become more visible ambassadors of our field within these communities. We can serve as recovery witnesses to the larger culture, sharing stories at every opportunity about lives transformed by addiction treatment and recovery. We can try to reconnect treatment, recovery and community.

About the Authors: William White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems and author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Russell Hagen is The CEO of Chestnut Health Systems and a board member of the National Association of Addiction Treatment Providers.

References

Mulford, H. (1976). *Alcohol abuse and citizen action: The community counselor/consultant approach*. Presented at the Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependence, Toronto, Canada, June 20-25, 1976.

White, W. (2002) A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly,* 19(4), 1-32.

White, W. (2003) The road not taken: The lost roots of addiction counseling. *Counselor,* 4(2), 22-23.



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. & Taylor, P. (2006) A new recovery advocacy movement. Posted at **www.williamwhitepapers.com**

A New Recovery Advocacy Movement

William L. White and Pat Taylor

People in recovery from addiction, their families, friends and allies are on the move. Some are calling on mayors, governors and legislators to change policies to make it possible for people to get needed treatment and recovery support services. Others are joining National Alcohol and Drug Addiction Recovery Month celebrations that draw tens of thousands of people and extensive media coverage.

Local communities of recovery are organizing and sharing ideas, resources and experiences. A grass roots media campaign (see www.recoveryiseverywhere.org) is countering stigma and putting a positive face on recovery. A network of thousands of recovery homes is spreading rapidly to small towns and large cities. Recovery High Schools are flourishing, as are special programs for the growing number of recovering people entering or returning to college. Innovative peer-based recovery support services, ranging from Recovery Support Centers to growing networks of recovery coaches are testimony to new creative solutions to addiction. Something is happening in our communities -- a renewed spirit of service and activism that has been christened the New Recovery Advocacy Movement.

Faces & Voices of Recovery, the National Council on Alcoholism and Drug Dependence, the Legal Action Center, the Johnson Institute, the Center for Substance Abuse Treatment's Recovery Community Services Program grantees such as White Bison, Association of Persons Affected by Addiction (APAA) and Connecticut Community for Addiction Recovery (CCAR) and hundreds of new grassroots recovery community organizations are all part of this exciting movement. Recovering people are collaborating with visionary professionals to communicate to the world that addiction recovery is a reality for millions of people and their families. This movement is calling for a vanguard of recovering people and their families and friends to stand together as living proof of this proposition.

Individual recovery advocates and recovery community organizations are pursuing several core strategies within this movement. They include:

- *Building strong, grassroots organizations* that develop recovery leaders, offer opportunities for recovering people to express their collective voice and provide a forum for community service.
- *Advocating for meaningful representation and voice* for people in recovery and their family members on issues that affect their lives.

- *Assessing needs* related to the adequacy and quality of local treatment and recovery support services.
- *Educating the public, policymakers and service providers* about the prevalence and pathways of addiction recovery.
- *Developing human and fiscal resources* by expanding philanthropic and public support for addiction treatment, recovery support services and recovery advocacy and cultivating volunteerism within local communities of recovery.
- *Advocating for policy changes* at the local, state and federal levels that promote recovery and remove barriers to recovery.
- *Celebrating recovery from addiction* through public events that offer living testimony of the transformative power of recovery.
- *Supporting research* that illuminates effective strategies and the processes of long-term recovery.

If you want to know more about or be part of this growing movement, contact the national Faces & Voices of Recovery campaign at www.facesandvoicesofrecovery.org.

Since its inception, this column has described the history of recovery in America. Come join us today in shaping the future of recovery in America.

William White (bwhite@chestnut.org) is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Pat Taylor (pat.taylor@verizon.net) is the Executive Director of Faces & Voices of Recovery.

Source: www.facesandvoicesofrecovery.org/pdf/White%20Publications/ANewRecoveryAdvocacyMovement.pdf



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.L. (2007). A recovery revolution in Philadelphia. *Counselor*, 8(5), 34-38.
Posted at **www.williamwhitepapers.com**

A Recovery Revolution in Philadelphia

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The City of Philadelphia has a long and distinguished role in the history of addiction treatment and recovery in America. One of the city's most famous and beloved sons, Dr. Benjamin Rush (1746-1813), was the first to articulate a disease concept of chronic drunkenness and call for the creation of special institutions for the care of the inebriate. Philadelphia's Franklin Reformatory Home for Inebriates (founded 1872) was among the most prominent of early inebriate homes and asylums. When a lay alcoholism therapy movement rose in the early twentieth century, Philadelphia was again distinguished by the collaboration of lay alcoholism therapist Francis Chambers and noted psychiatrist Dr. Edward Strecker at the Institute of the Pennsylvania Hospital. Chambers' acceptance as an interdisciplinary team member in one of the nation's most prominent psychiatric hospitals stands as an important milestone in the professionalization of addiction counseling (White, 1998).

In the mid-1940s, Philadelphia physicians A. Wiese Hammer, C. Dudley Saul, William Turnbull, and John Stauffer worked with a local committee of Alcoholics Anonymous to establish an alcoholism unit at Philadelphia General Hospital. Such units were pre-dated by decades and set the stage for the later rise of modern hospital-based addiction treatment. In 1968, Gaudenzia House joined the ranks of the America's earliest therapeutic communities, and in that same year, Eagleville Hospital and Rehabilitation Center became one of the first modern centers to fully integrate the treatment of alcoholism and drug addiction within the same facility.

As a national addiction treatment infrastructure emerged, Philadelphia continued to be a center of intervention through the family-centered work of Drs. Alfred Friedman, Jack Friedman, Duke Stanton, and Ivan Nagy at the Philadelphia Psychiatric Center (now the Belmont Center) and the Philadelphia Child Guidance Center, and Dr. George Woody's work on the treatment of opiate dependence on behalf of the Philadelphia Veterans Administration. Philadelphia also garnered national recognition for its vibrant recovery home movement (led by the Rev. Henry Wells and One Day at a Time) and its addiction-related research activities (e.g., the work of such individuals as Drs. Charles O'Brien, Tom McLellan, and James McKay).

Today, Philadelphia is poised to exert an even greater influence on the future of addiction treatment. This article describes the behavioral health system transformation process that is underway in Philadelphia and discusses how the innovations in Philadelphia will affect addiction counselors across the country.

The Context for Change

Several national trends form a backdrop to the dramatic changes that are unfolding within the City of Philadelphia's behavioral health care system. The first and most important of these trends is the explosive growth in addiction recovery mutual aid structures (support groups, clubhouses, recovery support centers, recovery homes, recovery schools, recovery job co-ops) and the rise and maturation of vibrant grassroots recovery advocacy movements in both the mental health and addiction arenas. These movements are calling upon traditional mental health and addiction treatment agencies to transform themselves into "recovery-oriented systems of care" and to use recovery as a conceptual bridge to improve services for persons with co-occurring disorders (White, 2005; White & Davidson, 2006). These movements have exerted a profound influence on national behavioral health policy, as reflected in the recommendations of the President's New Freedom Commission Report *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-level system transformation efforts (such as the work of the Connecticut Department of Mental Health and Addiction Services) reflect this trend to integrate behavioral health services within a recovery-oriented system of care. In the addictions field, system transformation efforts are also being fueled by research-based calls to shift 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).

In addition to these broader influences, three local milestones set the stage for dramatic changes in Philadelphia's behavioral healthcare system. The closing of the Philadelphia State Hospital in 1990 marked the final philosophical shift from an institutional to a community-based service model. The 1997 creation of Community Behavioral Health (CBH), a private non-profit managed behavioral health care organization, gave the City of Philadelphia direct control over the majority of the funds it expends for behavioral health care services. The final stage-setting event was the creation of the Department of Behavioral Health and Mental Retardation Services (DBH/MRS) in 2004 and the recruitment of Dr. Arthur Evans to lead the behavioral healthcare systems innovations at DBH/MRS. The creation of DBH/MRS, which provided an opportunity to weave CBH, the Office of Mental Health, and the Coordinating Office for Drug and Alcohol Abuse Programs into an integrated behavioral health care system, marked a critical milestone in Philadelphia's system transformation process.

Other influences that made Philadelphia an ideal laboratory for such sweeping innovation were the political commitment of Mayor John F. Street to reform behavioral health services, a strong addiction recovery advocacy organization, an established network of more than 85 addiction treatment providers, growing interest in alcohol and other drug problems 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.

The Revolution Defined

Transforming behavioral health care systems involves revolutionary changes in four areas: core values and concepts, constituency relationships, service practices, and funding and regulatory policies. Here is how changes in these areas unfolded and continue to unfold in the City of Philadelphia.

Core Values: Behavioral health system transformation in Philadelphia started by involving everyone in the process—particularly recovering people and their families. A lot of time was spent asking questions and listening to people's ideas about how the existing behavioral healthcare system could be changed to better meet their needs. What emerged after months of such discussions was 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. A Recovery Advisory Committee clarified that vision by developing a consensus definition of recovery and by defining nine core recovery values. The nine core values were hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach. Seen as a whole, these values shifted the focus of attention from the interventions of professional experts to the experience and needs of recovering individuals and families. The recovery definition and recovery core values were then used to guide the system transformation process in both mental health and addiction service settings.

Relationship Reconstruction: If there is a single word that describes the changing pattern of relationships within the system transformation process in Philadelphia, that word is *partnership*. Relationships between service practitioners and service consumers and between DBH/MRS and its local service providers are moving from authority-based relationships to relationships based on mutual respect and collaboration. Recovery representation is being promoted at all levels of system decision making. The focus on recovery has also resulted in an emphasis on the value of peer-based recovery support services. Considerable efforts are being invested to expand the availability, quality, and sustainability of recovery support services and to expand the settings in which such services are available. New relationships, such as the linkage between treatment agencies, the faith community, and other indigenous institutions, are also a visible part of the system transformation process. DBH/MRS has assertively involved recovering people and their families at every stage of the systems transformation process in order to affirm that recovery is a living reality in the City of Philadelphia.

Changes in Service Practices: Long-tenured addiction counselors have witnessed the rise and fall of many faddish ideas, many of which generated little if any sustained changes in clinical practices. Asking "How will this new recovery orientation change what we do with clients?" is a reasonable response in light of such history. Based on the system transformation process to date in Philadelphia, here are 10 ways clinical practices are likely to change in similar system transformation efforts across the country.

1. Engagement: Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; renewed focus on the quality of the service RELATIONSHIP.

2. Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.

3. Retention: Increased focus on service retention and decreasing premature service disengagement; use of outreach workers, recovery coaches, and advocates to reduce rates of client

disengagement and administrative discharge.

4. Role of Client: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries.

5. Service Relationship: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."

6. Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development).

7. *Service Dose/Duration*: Dose and duration of total services will increase while number and duration of acute care episodes will decline; emphasis shifts from crisis stabilization to ongoing recovery coaching; great value placed in continuity of contact in a primary recovery support relationship over time.

8. Service Delivery Sites: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater use of community organization skills to build or help revitalize indigenous recovery supports where they are absent or weak.

9. Post-treatment Checkups and Support: Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention.

10. Attitude toward Re-admission: Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.

Changes in Funding and Regulatory Policies: The conceptual, relationship, and practice changes described above cannot be effectively implemented and sustained without substantial accompanying changes in funding and regulatory policies. In Philadelphia, DBH/MRS is working with its multiple constituencies to plan and implement such changes. To date, the focus has been on providing regulatory relief (reducing duplicative and excessive regulatory requirements), generating more recovery-focused regulatory standards, shifting the focus of program monitoring from one of policing to one of consultation and support, generating new RFPs for recovery-focused service initiatives, and exploring models for long-term funding of recovery support services. The DBH/MRS has invited the State Department of Public Welfare to join it in using the City of Philadelphia as a laboratory for recovery-focused regulatory and policy reform.

The Revolution Spreads

Philadelphia is not alone in pursuing this recovery revolution, but DBH/MRS is among the vanguard of those behavioral health systems seeking to radically transform their systems of care as a whole. There are several indications that such transformation may be the wave of the future. First, there is a growing body of research documenting the limitation of acute care models of addiction treatment (see White, Boyle, & Loveland, 2002) and

affirming the potential role of assertive and sustained approaches to continuing care (Godley, Godley, Dennis, Funk, & Passetti, 2002; Dennis, Scott, & Funk, 2003). In tandem with these findings, major funding organizations are exploring the potential of peer-based recovery support services as an adjunct or alternative to traditional treatment services in an effort to improve long-term recovery outcomes (see http://rcsp.samhsa.gov/). As federal and state agency leaders seek ways to implement recovery-focused policy recommendations, their eyes will be drawn to states like Connecticut and to urban behavioral health care systems such as the Philadelphia Department of Behavioral Health who are paving the way for such innovation.

Getting Prepared

And what will all this mean for the addiction counselor? I would offer the following prescriptions for addiction counselors whose communities will be embracing similar behavioral health system transformation efforts.

- Find ways to learn about, and, if you are so inclined, to participate in the new recovery advocacy movement (see www.facesandvoicesofrecovery.org for key papers on this movement and a national directory of recovery advocacy groups).
- Become a student of recovery: study the growing body of recovery-focused research reports on the varieties of recovery experience and the effects of professional- and peer-based support on long-term recovery processes and outcomes.
- Embrace local system transformation efforts by volunteering to serve on advisory groups, task forces, and training committees.
- Provide leadership in advocating recovery-focused changes in service practices within your own service site.
- Seek out opportunities to explore how traditional ethical standards governing addiction counseling (based on ethical standards governing brief psychotherapy) will need to become more nuanced and, in some cases, significantly altered within models of sustained recovery support.

A revolution in behavioral health care is unfolding in the City of Philadelphia. If that revolution has not already reached your community and your organization, it is likely to do so in the very near future. As addiction counselors, we need to prepare ourselves and contribute our core values, knowledge, and skills to such system transformation efforts. What is at stake here is the future of addiction treatment and recovery in America.

Resource Note: Readers wishing to know more about recovery-focused system transformation are encouraged to read two recently released papers:

Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change. (2007). Philadelphia: Department of Behavioral Health and Mental Retardation Services.

An Integrated Model of Recovery-Oriented Behavioral Health Care. (2007). Philadelphia: Department of Behavioral Health and Mental Retardation Services.

Additional information on behavioral health system transformation in Philadelphia is available online at:

http://www.phila.gov/dbhmrs/initiatives/INT_index.html.

An interview with Dr. Arthur Evans about the Philadelphia systems transformation process is posted at: www.williamwhitepapers.com

Acknowledgement: I wish to thank Dr. Arthur C. Evans, Dr. Ijeoma B. Achara-

Abrahams and Roland Lamb of the Philadelphia Department of Behavioral Health and Mental Retardation Services for their helpful comments on an early draft of this article.

About the Author: William L. White, MA, 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*.

References

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.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment: Preliminary outcomes. *Journal of Substance Abuse Treatmen*t, *23*(1), 21-32.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

White, W. (2005) Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-130.

White, W., & Davidson, L. (2006). System transformation. Recovery: The bridge to integration? Part one. *Behavioral Healthcare Tomorrow, 26*(11), 22-25.

White, W., & Davidson, L. (2006). System transformation. Recovery: The bridge to integration? Part two. *Behavioral Healthcare Tomorrow, 26*(12), 24-26.



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 Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. Journal of Substance Abuse Treatment, 33, 221-228. Posted at **www.williamwhitepapers.com**

What is recovery?
A working definition from the Betty Ford Institute

Abstract

There is an unknown but very large number of individuals who have experienced and successfully resolved dependence on alcohol or other drugs. These individuals refer to their new sober and productive lifestyle as “recovery.” Although widely used, the lack of a standard definition for this term has hindered public understanding and research on the topic that might foster more and better recovery-oriented interventions. To this end, a group of interested researchers, treatment providers, recovery advocates, and policymakers was convened by the Betty Ford Institute to develop an initial definition of recovery as a starting point for better communication, research, and public understanding. Recovery is defined in this article as a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship. This article presents the operational definitions, rationales, and research implications for each of the three elements of this definition.



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: Valentine, P., White, W. & Taylor, P. (2007) The recovery community organization: Toward a definition. Posted at **www.williamwhitepapers.com**

The Recovery Community Organization: Toward A Working Definition and Description

Phillip A. Valentine, William L. White and Pat Taylor

What is a recovery community organization?

A recovery community organization (RCO) is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services (P-BRSS). The broadly defined recovery community – people in long-term recovery, their families, friends and allies, including recovery-focused addiction and recovery professionals – includes organizations whose members reflect religious, spiritual and secular pathways of recovery. The sole mission of an RCO is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Public education, policy advocacy and peer-based recovery support services are the strategies through which this mission is achieved.

How many recovery community organizations are there in the United States?

There are a number of national organizations, some with state and local affiliates, whose primary focus is on the needs of individuals, families and communities seeking or in recovery from alcohol and other drug addiction. The National Council on Alcoholism and Drug Dependence (NCADD), founded over 60 years ago, can be described as the nation's first modern recovery community organization. Today, many of its affiliates have spawned or operate as recovery community organizations. There has been a recent growth in new grassroots recovery advocacy and support organizations linked nationally through the activities of Faces & Voices of Recovery (Faces & Voices). Some of these organizations operate at the state level with local and/or city-wide chapters or affiliates, such as FAVOR-SC with four local affiliates; People Advocating Recovery (KY) with six chapters; and Alabama Voices for Recovery with three chapters. Also, a subset of RCOs has emerged from recovery-focused ministries. The National Alliance of Methadone Advocates (www.nama.org), Advocates for Recovery through Medicine (ARM) (www.methadonetoday.org/armhelp.htm), the National Alliance of Advocates

for Buprenorphine Treatment (NAABT) (www.naabt.org) and the Opioid Dependence Resource Center http://www.methadone.net all provide assistance for those in medication-assisted recovery. Other national organizations, some with state and local affiliates, are focused on supporting recovery for particular ethnic groups. One example is White Bison (http://www.whitebison.org/), whose mission is focused on recovery advocacy and support in Native American communities. All told there are over 175 local and state recovery community organizations in the US.

How are recovery community organizations formed?

Recovery community organizations are usually birthed by persons in personal and/or family recovery in response to unmet needs in local communities. They often exist as voluntary advocacy and service organizations for some time before they have funding to support their activities on a more formal basis. Faces & Voices of Recovery provides the connecting tissue between these groups at a national level. A directory of these organizations is posted on the Faces and Voices website (www.facesandvoicesofrecovery.org). If there is not an RCO in your community, consider starting one. Papers describing the history of recovery advocacy and P-BRSS and resources for starting an RCO are also posted at the Faces & Voices website.

What are the Core Elements of a Recovery Community Organization?

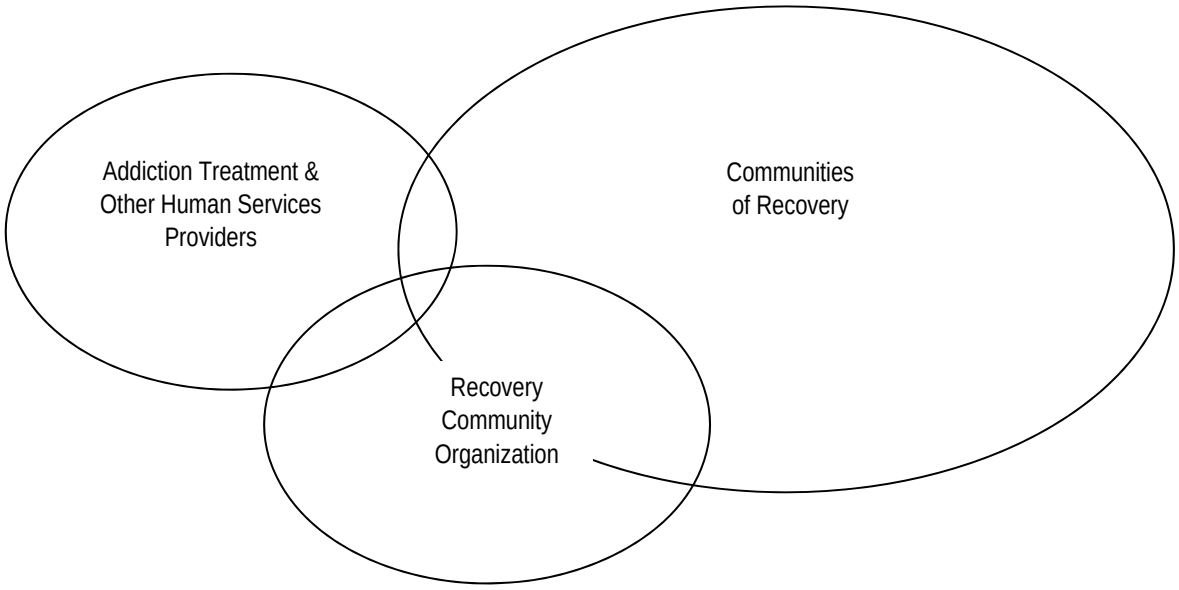
In our work with RCOs around the country, we believe that there are three characteristics that distinguish RCOs from other organizations concerned with alcohol- and other drug-related problems.

1. Recovery Vision: The RCO, its leaders and its members have a singular goal: enhancing the quantity and quality of support available to people seeking and experiencing long-term recovery from alcohol and other drug addiction.

2. Authenticity of Voice: Authenticity of voice means that an RCO represents one or more communities of recovery. There are some that aspire to represent the widest possible diversity of those communities (e.g., Faces and Voices, CCAR, PRO-ACT), but most represent some portion of the total. Authenticity comes from the connection to one or more communities of recovery and not the representation of all such communities. Organizations should not be excluded from the RCO definition if they represent a specific constituency unless that constituency is NOT a community of recovery and constitutes a very different organizational entity.

Ideally, an RCO achieves authenticity by representing diverse communities of recovery (or diverse voices of recovery within a specific construct) and assuring that its leaders accurately represent the voices of those communities. The RCO is led (via its board of directors, managers, staff, volunteers and membership) by a majority of people representing local communities of recovery. Those serving in these roles are comfortable self-identifying as persons in long-term recovery, family members, friends and allies of recovery and offering themselves and their personal stories as living proof of the transformative power of recovery. Healthy organizations strive to include people representing different styles and lengths of recovery as well as diversity by age, gender, ethnicity, sexual orientation, and political and religious affiliation. The voices of individuals and family members affected by alcohol and other drug addiction are prominent at all levels of the organization. Vibrant RCOs insure that the voices of people who have experienced all forms of recovery are heard and embraced and that the organization's public education, advocacy and recovery support services respond to the broadest spectrum of local recovery needs.

3. Independence: We believe that an RCO is most credible and effective as a stand-alone entity. The leading RCOs are open to multiple levels of collaboration with a wide variety of other organizations, but they are not under the control of an organization that may have conflicting interests. For example, RCOs may work closely with, but are independent of addiction treatment providers. The RCO's real strength is drawn not from its links to other service organizations but from the authentic voice of the individuals in the recovery community who relate to and actively support it. An RCO serves as a bridge between diverse communities of recovery, the addiction treatment community, governmental agencies, the criminal justice system, the larger network of health and human services providers and systems and the broader recovery support resources of the extended community (e.g., recovery-conducive housing, education, employment, and leisure). The RCO can effectively recruit members of local communities of recovery to advocate on behalf of the needs of those seeking and in recovery and to give back to their communities through acts of voluntary and paid service to others seeking or in recovery. The RCO engages clinical treatment providers by offering those they serve a viable source of recovery support before, during and following treatment and, in some cases, as an alternative to treatment. The figure below illustrates how we see the RCO nested within larger systems and serving as a bridge between local communities of recovery and local professional service providers.



What are the core strategies of RCOs?

There are 8 core strategies of RCOs (White & Taylor, 2006):

- *Building strong, grassroots organizations* that develop leaders, offer opportunities for recovering people to express their collective voice and provide a forum for community service.
- *Advocating for meaningful representation and voice* for people in long-term recovery and their family members on issues that affect their lives.
- *Assessing needs* related to the adequacy and quality of local treatment and recovery support services.

- *Educating the public, policymakers and service providers* about the prevalence and multiple pathways of addiction recovery.
- *Developing human and fiscal resources* by expanding philanthropic and public support for addiction treatment, recovery support services and recovery advocacy and cultivating volunteerism within local communities of recovery.
- *Advocating for policy changes* at the local, state and federal levels that promote recovery and remove barriers to recovery.
- *Celebrating recovery from addiction* through public events that offer living testimony of the transformative power of recovery.
- *Supporting research* that illuminates effective strategies and the processes of long-term recovery.

The most central of these activities are public education, policy advocacy and peer-based recovery support services.

Public Education and Policy Advocacy: Advocacy can take many forms, but most RCOs educate the public by seeking to "put a positive face and voice on recovery" using a vanguard of individuals and families willing to offer their lives and stories as testimony that long-term recovery is a reality. The focus of public education and outreach is on communicating the reality of long-term addiction recovery and the many pathways and styles of such recovery to the culture as a whole, policymakers, the media and local communities. This education is intended to replace pessimism with the hope and healing power of recovery combating the stigma associated with addiction. It provides mainstream society a highly visible solution to the staggering problems associated with alcohol and other drug addiction. Probably the best-known of these activities is the observance of National Alcohol and Drug Addiction Recovery Month each September.

Public policy advocacy is aimed at promoting policies that widen the doorways of recovery and assure resources to enhance the quality of long-term recovery, ending discriminatory policies. For example, Faces & Voices advocates helped restore funding for the federal government's Recovery Community Services Program (RCSP) and restore the rights of students with drug convictions to federal student financial aid; the McShin Foundation helped save Medicaid funding for addiction treatment in the state of Virginia, RI Cares helped overturn a ban on voting rights for felons; the Connecticut Community for Addiction Recovery (CCAR) influenced the state pardons process; the Addictions Coalition of Delaware helped remove barriers to work facing people with felony convictions; and Friends of Recovery VT secured state funding for nine Recovery Community Centers.

Peer-Based Recovery Support Services (P-BRSS): One of the most significant recent trends in the addictions field (and in related mental health, public health, and child welfare fields) is the emergence of peer-based and other recovery support services that are distinct from professionally-directed clinical services offered by addiction treatment organizations or other helping institutions. Peer-based recovery support services cover a wide range of activities not generally offered by treatment providers. Such services include but are not limited to peer support (e.g., recovery coaching), housing, transportation, vocational training, employment services, telephone support, support groups, system navigation, recovery resource dissemination, life skills training and sober social activities. A recent trend is to deliver these services through Recovery Community Centers. One model for a Recovery Community Center can be found on the CCAR website at http://ccar.us/recoverycntrs.htm along with links to that organization's four Recovery Community Centers.

The federal government's Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment's Recovery Community Services Program (RCSP) and Access To Recovery (ATR) grants have helped several states and over fifty community-based

organizations build their capacity to deliver peer-based and other recovery support services. Traditional treatment providers, facilitating organizations, faith-based organizations and recovery community organizations have all been awarded funding under RCSP and ATR. In addition, a number of states and private foundations are providing funding for peer-based and other recovery support services and some insurers are reimbursing for these services.

Funding sources, both public and private; regulators and evaluators will need to explore several key issues related to the public education, policy advocacy, and peer-based recovery support service activities of organizations as they think about peer-based recovery support services. These issues encompass such questions as the following:

- Do long-term recovery outcomes for individuals and families differ when P-BRSS are delivered through different types of organizations?
- Are outcomes clearly superior when services are delivered by one type of organization over another? Do these outcomes vary for particular types of populations to be served and across ethnic/cultural contexts?
- Will a community's long-term recovery capital[1] be strengthened more depending on the type of organization delivering those services?
- How can continuity of care be best maintained across what are potentially multiple service organizations and multiple levels of care?
- How can the highest quality and highest number of P-BRSS be delivered with available funds?

One relatively new entity that is delivering P-BRSS is the recovery community organization (RCO). This essay postulates that RCOs are a legitimate and potentially preferred provider of P-BRSS.

How do recovery community organizations differ from addiction treatment providers and from recovery mutual aid societies?

RCOs take many forms but as a whole differ significantly from addiction treatment organizations and recovery mutual aid groups. As noted earlier, RCOs are independent, meaning that they are usually not part of organizations involved in activities beyond recovery-focused public education and policy advocacy and the delivery of peer-based recovery support services. They are led by individuals who are representative of the recovery community. They are committed to recovery-related social change (e.g., recovery-focused community education, advocating pro-recovery social policies) and they invest considerable resources in organizing recovery resources within their local communities. RCOs are not a program of personal recovery nor do they promote a particular pathway to recovery (e.g., RCO volunteers do not act as Twelve Step sponsors in their volunteer role). RCOs celebrate the multiple pathways of recovery and offer resources to help people access those frameworks of recovery.

For RCOs that offer services to individuals and their families, the focus tends to be on peer-based, non-clinical recovery support services. RCOs bridge the gap between a clinical treatment episode and long-term recovery through the provision of P-BRSS. RCO staff and volunteers do NOT provide professional assessment nor do they provide addiction counseling or related clinical services. Other distinctive characteristics of RCOs are their conscious effort to achieve cultural diversity, their emphasis on leadership development within the recovery community (e.g., building advocacy skills as part of taking personal responsibility for one's

[1] By community recovery capital, we mean the total pool of resources that can be brought to bear to initiate and sustain recovery from severe and complex alcohol and other drug problems and to enhance the quality of life of individuals and families in recovery.

citizenship). RCOs emphasize people's recovery potential rather than their historical problems and pathologies. They also promote the development of local core recovery values and ethical guidelines to govern the organizational and volunteer decision-making in advocacy and peer-support activities.

How are recovery community organizations funded?

RCOs receive funds from a wide variety of sources. They may receive federal funding through the Center for Substance Abuse Treatment's RCSP (which received more than 170 applications for six grants in its last funding cycle), Access to Recovery, Recovery Month and other federal programs such as those for people reentering communities after incarceration. In some states with a more recovery-oriented system of care (e.g., CT, VT, AZ, OR), RCOs receive grants or are able to bill for the delivery of P-BRSS through the state Medicaid program.

At the local level, hundreds of businesses and local units of governments have provided support to RCO events. Private foundations have also provided financial support for particular RCO-sponsored activities or special events. The Christopher D. Smithers Foundation funded the printing and North American distribution of a White Bison, Inc. book on the history of recovery among Native American tribes. The Robert Wood Johnson Foundation has supported Faces & Voices of Recovery and that organization's support of RCOs since its founding in 2001. State-level recovery community organizations like People Advocating Recovery (PAR) in Kentucky have enjoyed support from health care conversion foundations like the Greater Cincinnati Health Foundation. NAABT, Inc. has received funding from pharmaceutical companies in the form of "Unrestricted Educational Grants. CCAR receives annual funding from the Connecticut Department of Mental Health and Addiction Services (DMHAS) and recently funded a technology upgrade through a grant from the Hartford Foundation for Public Giving. This support has not met the fiscal needs of the growing numbers of recovery community organizations that are growing in size. Some RCOs are self-funded primarily from donations of those in recovery themselves and their circle of friends and associates. Many RCOs envision their long-term financial sustainability in terms of support from members of their local communities of recovery. This support is most often delivered through either paid memberships in the RCO, in response to individual giving campaigns or in event sponsorship.

Are there regulations or ethical guidelines governing recovery community organizations?

Most RCOs have a set of core values or an ethical code that guides individual and organizational decision-making. Some RCOs, like the Pennsylvania Recovery Organization – Achieving Community Together (PRO-ACT) has developed specific ethical guidelines for the delivery of P-BRSS (White, et al, 2007). In addition to these organization-driven guidelines, some states are developing credentialing standards for peer recovery support specialists that include a code of ethical conduct that an RCO will be required to adopt.

Have recovery community organizations been formally evaluated?

Most of the RCSP grantees and state-funded peer and other recovery support programs have undergone some level of project evaluation. Rigorous scientific studies that will be published in peer-review scientific journals are underway. Some RCOs have contracted with evaluators for specific projects. There is considerable scientific evidence for the effectiveness of the types of peer-based recovery support services that RCOs are providing. These P-BRSS include outreach and engagement, ancillary support during primary treatment, assertive linkage to communities of recovery, post-treatment monitoring and support and (when needed) early re-intervention (Kurtz & White, 2006). There is a growing body of scientific evidence suggesting

that post-treatment monitoring (recovery checkups and "assertive approaches to continuing care) and support can elevate recovery outcomes for adults (McKay, 2001; McKay, 2005; Dennis, Scott & Funk, 2003; Scott, Dennis, & Foss, 2005) and adolescents (Godley, Godley, Dennis, et al, 2002, 2007) and that such services can be delivered in a telephone-based format (McKay, Lynch, Shepard, & Pettinati, 2005).

An example of the promising data coming out of P-BRSS pilot project utilizing a peer telephone recovery support process is that being provided by CCAR —a project funded in part by federal Access To Recovery dollars (Broffman, Fisher, Gilbert, & Valentine, 2006). In 2006, CCAR volunteers made 4,688 attempts to call 339 different recoverees and made contact 1,828 times (making contact means the caller actually spoke with the recoveree). Out of those 1,828 contacts the recoveree indicated they were still in recovery 1,697 times or 92.8% of the time. 38 times people said they had relapsed and on 13 of those occasions the volunteer was able to help the person back into recovery. Many recoverees have been enrolled for more than one full year. Of note is the increase in the number of unduplicated recoverees; in the first three months of 2007, CCAR had called more individual recoverees, 380, than in all of 2006. Based on this preliminary data and increased demand for such services, the Connecticut Department of Mental Health and Addiction Services posted a statewide RFQ (Request for Qualifications) for Telephone Peer Support Services in April, 2007.

What are the organizational contexts from which P-BRSS are being delivered?

P-BRSS are being delivered out of different organizational contexts (e.g., treatment organizations, RCOs, faith-based recovery ministries.) These organizations are providing a varying array of services delivered by individuals who are paid, volunteers, or volunteers whose expenses are paid by the sponsoring organization. We believe the growing number of RCOs delivering P-BRSS will become an increasingly prominent feature in the landscape of addiction treatment and recovery in America.

Acknowledgements

Special thanks to Steve Arndt, June Gertig, Tom Hill, Bill Layfield, Carol McDaid, and David Whiters for providing thoughtful commentary in helping to shape this paper.

About the Authors: Phillip A. Valentine is Executive Director of the Connecticut Community for Addiction Recovery (CCAR), http://ccar.us, and in recovery since 12/28/1987. William White is the author of *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement* (2006) whose proceeds support the advocacy work of both Faces & Voices of Recovery and the Johnson Institute. Pat Taylor is Executive Director of Faces & Voices of Recovery.

References

Broffman, T., Fisher, R, Gilbert, W. & Valentine, P. (2006). A direct contact after discharge. Connecticut agencies test telephone recovery support conducted by peers. Addiction Professional, March-April, pp. 1-4 Accessed June 19, 2007 at http://www.addictionpro.com/ME2/dirmod.asp?sid=9B6FFC446FF7486981EA3C0C3CCE4943&nm=ArtIcles%2FNews&type=Publishing&mod=Publications%3A%3AArticle&mid=8F3A7027421841978F18BE895F87F791&tier=4&id=97C7675F4CA94695BE77F2397C589AE0

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.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment: Preliminary outcomes. *Journal of Substance Abuse Treatmen*t, *23*(1), 21-32.

Godley M.D., Godley S.H., Dennis M.L., Funk R.R., & Passetti. L.L. (2007).The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. *Addiction*. 102(1):81-93.

McKay, J. R. (2001). Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects. *Evaluation Review, 25*(2)*,* 211-232.

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*(11), 1594-1610.

McKay, J.R.; Lynch, K.G.; Shepard, D.S.; and Pettinati, H.M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry* 62(2):199-207.

Scott, C. K., Dennis, M. L., & Foss, M. A. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence, 78*(3), 325-338.

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.

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.

White, W. & Taylor, P. (2006). A New Recovery Advocacy Movement. Posted at www.facesandvoicesofrecovery.org



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: Published article with photo plates—White, W. (2007). The new recovery advocacy movement in America. *Addiction*, 102, 696-703.Posted at **www.williamwhitepapers.com**

Photo History Series 5
The New Recovery Advocacy Movement in America

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Barbara Tuchman once suggested that the most difficult task of the historian is to capture the contextual roots and cultural significance of vibrant social movements while they are "still smoking" (1). This essay describes the history, organizational structure, goals, core ideas and strategies of a newly emerging addiction recovery advocacy movement in the United States and illustrates the distinctive character of this movement through photographic images.

Historical Context Several conditions set the stage for the rise of a new addiction recovery advocacy movement in the United States in the late 1990s. Many of the goals of the mid-twentieth century "modern alcoholism movement" seemed to be fulfilled in the rise of community-based and private addiction treatment in the 1970s and 1980s (2, 3), but recovery advocates who helped birth modern addiction treatment in America expressed concern in the 1990s that something had been lost through the professionalization and commercialization of addiction treatment. In their view, the founding vision of professionally-guided entry into recovery had mutated into a multi-billion dollar industry that viewed recovery as an afterthought or adjunct of itself. There was a sense that addiction treatment had become detached from the larger and more enduring process of addiction recovery and that addiction treatment organizations had become disengaged from the grassroots communities out of which they were born. There was also growing evidence that earlier successes in altering public perceptions and public policies toward alcohol and other drug (AOD) problems had deteriorated in the 1980s and 1990s via the restigmatization, demedicalization and recriminalization of such problems (4). Trends inside the treatment industry and shifts in broad cultural attitudes and social policies set the stage for a new politicized coalition of recovering people and their families and visionary addiction treatment professionals.

Organization New grassroots recovery advocacy organizations rose in the late 1990s, mirroring the earlier rise of local alcohol and drug councils in the 1960s and 1970s. At the same time, many of the local affiliates of the National Council on Alcoholism and Drug Dependence (NCADD)

sought to revive their historical missions following the realization that operating large, complex service organizations had diverted them from their original mission of public education and public policy advocacy. In the face of this awakening, the Johnson Institute used its Leadership Forum to launch the Alliance Project—the first effort to link these new and existing fledgling recovery advocacy groups into a national network. In 2000, the Alliance Project commissioned focus groups and a first-ever national survey of the recovery community by Peter D. Hart Associates, called The Face of Recovery.

In 1998 the Center for Substance Abuse Treatment's Recovery Community Support Program began providing seed money for local recovery advocacy efforts and continued that support until 2002, at which time its focus shifted to the development of peer-based recovery support services. As the new recovery advocacy movement gained momentum, other organizations such as the Legal Action Center offered support to address issues of stigma and discrimination.

In October 2001, more than 200 recovery advocates from 36 states met in St. Paul, Minnesota under the leadership of the Alliance Project to develop a national recovery advocacy campaign. Presentations at the 2001 recovery summit included addresses by two congressional leaders, Representatives Jim Ramstad and Paul Wellstone, who had been public about their own recovery experiences (Plate One). Emerging from the 2001 recovery summit was the Faces and Voices of Recovery campaign guided by an advisory committee made up of regional representatives of local recovery advocacy organizations. Early funding from the Johnson Institute and subsequent financial support from the Robert Wood Johnson Foundation and the Center for Substance Abuse Treatment allowed Faces and Voices of Recovery to hire its own staff and establish its independence as a nonprofit corporation in 2004 (see www.facesandvoicesofrecovery.org). At present, the recovery advocacy movement is led at a national level by a coalition of Faces and Voices of Recovery, the Johnson Institute, the Legal Action Center and NCADD. At a local level, the movement is represented by more than 125 recovery advocacy organizations and more than 8,000 self-identified core recovery advocates. During September 2006, more than 40,000 individuals and 45 sponsoring organizations participated in Faces and Voices of Recovery's Rally for Recovery education and celebration events (5).

Movement Goals The espoused 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 living role models that illustrate the diversity of those recovery solutions, 3) counter public attempt to dehumanize, objectify and demonize those with AOD problems, 4) enhance the variety, availability, and quality of local/regional treatment and recovery support services, and 5) remove environmental barriers to recovery by promoting laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems (4).

Core Values and Ideas The core values of this new generation of recovery advocacy organizations reflect a recognition of: 1) the primacy of personal recovery as a platform for political advocacy, 2) the need for authentic, grassroots recovery representation in the development of addiction-related policies and programs, 3) the importance of developing local and national recovery advocacy leadership, and 4) the value of cultural diversity, including representation of diverse pathways and styles of addiction recovery. Where earlier American social movements sought to alter public perceptions of and public policies toward those with AOD problems by redefining the problem ("alcoholism is a disease"), altering perceptions of those with the problem ("the alcoholic is a sick person") or promoting a particular intervention ("treatment works")(6, 7), the new recovery advocacy movement shifts the focus from the problem and the intervention to the solution (8, 4). The core messages that have

marked the earliest stages of this movement include the following:

1) Addiction recovery is a living reality for individuals, families and communities (see www.recoveryiseverywhere.org) (Plates Two and Three),
2) There are many (religious, spiritual, secular) pathways to recovery,
3) Recovery flourishes in supportive communities,
4) Recovery is a voluntary process, and
5) Recovering and recovered people are part of the solution: recovery gives back what addiction has taken from individuals, families and communities (4).

This new movement is also suggesting that recovering people, through their silence and invisibility, have been part of the problem (Plate Four). Stigma did not diminish for other health conditions (e.g., cancer) until a critical mass of citizens personally knew someone who was in recovery from these conditions. The new recovery advocacy movement is challenging a vanguard of individuals and families in long-term addiction recovery to step forward and announce their presence within the American culture and to organize themselves as a political force (Plate Five).

Core Strategies To date, there are eight major strategies of the new recovery advocacy movement:

1) *Building strong, grassroots recovery advocacy organizations and linking these organizations into a national movement* that offers opportunities for recovering people to express their collective voice and participate in community service projects (Plate Six).
2) *Advocating for meaningful representation and voice at policy levels* for people in recovery and their family members on issues that affect their lives (Plate Seven).
3) *Assessing needs* related to the adequacy and quality of local treatment and recovery support services.
4) *Educating the public, policymakers and service providers* about the prevalence and pathways of addiction recovery.
5) *Expanding human and fiscal resources* by encouraging philanthropic and public support for addiction treatment, recovery support services, and recovery advocacy and by cultivating volunteerism within local communities of recovery.
6) *Creating recovery support centers* that delivery non-clinical, peer-based recovery support services.
7) *Celebrating recovery from addiction* through public events (recovery marches, rallies, concerts) that offer living testimony of the transformative power of recovery (Plates Eight, Nine & Ten).
8) *Supporting research* that illuminates effective strategies and the processes of long-term recovery.

Diversity Another feature that distinguishes the emerging recovery advocacy movement from its predecessors is the diversity of ethnic communities, pathways and styles of recovery, and institutional settings (e.g., recovery ministries within churches, recovery schools) that it is embracing. This diversity is represented by such organizations as White Bison, Inc. (Plates Eleven & Twelve), the El Paso Recovery Alliance (Plate Thirteen), Recovery Consultants of Atlanta, SpeakOUT: LGBT Voices of Recovery, the National Alliance of Methadone Advocates (NAMA), and Advocates for Recovery through Medicine (ARM). There are also groups such as the Connecticut Community of Addiction Recovery that have built strong, multi-ethnic recovery advocacy coalitions, and there are regional advocacy alliances such as the New England Alliance for Addiction Recovery.

A growing number of people recovering from AOD problems are using their personal transformations as a platform to advocate social change related to the sources of and solutions to community-wide AOD problems. The new recovery advocacy movement in America is transforming people who have been the country's problems into instruments of social action and community service.

References

1. Tuchman B. *Practicing history*. New York: Alfred A. Knopf; 1981.

2. Johnson B. *The alcoholism movement in America: a study in cultural innovation* [dissertation]. Urbana, IL: University of Illinois; 1973.

3. Roizen R. *The American discovery of alcoholism, 1933-1939* [dissertation]. Berkeley: University of California; 1991.

4. White W. *Let's go make some history: chronicles of the new addiction recovery advocacy movement*. Washington, DC: The Johnson Institute; 2006.

5. Taylor P. *Faces and Voices of Recovery: where we started* [unpublished manuscript]. Washington, DC: Faces and Voices of Recovery; 2006.

6. Anderson D. Alcohol and public opinion. *Q J Stud Alcohol* 1942; 3(3): 376-392.

7. Mann M. Formation of a National Committee for Education on Alcoholism. *Q J Stud Alcohol* 1944; 5(2): 354.

8. White W. Treatment works: is it time for a new slogan? *Addiction Professional* 2005; 3(1): 22-27. Plates

Plate 1: Representative Jim Ramstad (at podium) and late Senator Paul Wellstone address the 2001 Recovery Summit (Courtesy Gabrielle Antolovich)

Plate 2: Recovery is Everywhere Campaign Poster (Courtesy of Dawn Farm)

Plate 3: Recovery is Everywhere Campaign Poster (Courtesy of Dawn Farm)

Plate 4: Silence Poster (Courtesy of Missouri Recovery Network)

Plate 5: Buttons and bumper sticker collected at recovery celebration events (Courtesy of Illinois Addiction Studies Archives)

Plate 6: Recovery Ambassadors Workshop (training for recovery advocates) (Courtesy of Johnson Institute)

Plate 7: Joel Hernandez alleges recovery job discrimination before the Supreme Court (Courtesy of Johnson Institute)

Plate 8: Local Recovery Celebration March (Courtesy of Connecticut Community of Addiction Recovery)

Plate 9: Recovery Advocates Meet at National Capital in 2005 (Courtesy Faces and Voices of Recovery)

Plate 10: 2005 America Honors Recovery Honorees: Tom McHale, Elizabeth Scott, Jerry Moe, James McClain, Stacia Murphy, Mark Helijas and Jay Davidson (Courtesy of Johnson Institute)

Plate 11: Wellbriety Movement Council of Elders members Horace Aztell (Nez Perce), Dr. Henrietta Mann (Cheyenne) and Ozzie Williamson (Blackfeet) at recent Wellbriety Conference (Courtesy White Bison, Inc.)

Plate 12: Wellbriety Hoop of 100 eagle feathers used in Wellbriety Celebrations (Courtesy of White Bison, inc.)

Plate 13: Member of Circulo de Hombres performs at a recovery celebration in El Paso, Texas (Courtesy El Paso Recovery Alliance)



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: Published article with photo plates—White, W. (2007). The new recovery advocacy movement in America. *Addiction*, 102, 696-703.Posted at **www.williamwhitepapers.com**

Photo History Series 5
The New Recovery Advocacy Movement in America

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Barbara Tuchman once suggested that the most difficult task of the historian is to capture the contextual roots and cultural significance of vibrant social movements while they are "still smoking" (1). This essay describes the history, organizational structure, goals, core ideas and strategies of a newly emerging addiction recovery advocacy movement in the United States and illustrates the distinctive character of this movement through photographic images.

Historical Context Several conditions set the stage for the rise of a new addiction recovery advocacy movement in the United States in the late 1990s. Many of the goals of the mid-twentieth century "modern alcoholism movement" seemed to be fulfilled in the rise of community-based and private addiction treatment in the 1970s and 1980s (2, 3), but recovery advocates who helped birth modern addiction treatment in America expressed concern in the 1990s that something had been lost through the professionalization and commercialization of addiction treatment. In their view, the founding vision of professionally-guided entry into recovery had mutated into a multi-billion dollar industry that viewed recovery as an afterthought or adjunct of itself. There was a sense that addiction treatment had become detached from the larger and more enduring process of addiction recovery and that addiction treatment organizations had become disengaged from the grassroots communities out of which they were born. There was also growing evidence that earlier successes in altering public perceptions and public policies toward alcohol and other drug (AOD) problems had deteriorated in the 1980s and 1990s via the restigmatization, demedicalization and recriminalization of such problems (4). Trends inside the treatment industry and shifts in broad cultural attitudes and social policies set the stage for a new politicized coalition of recovering people and their families and visionary addiction treatment professionals.

Organization New grassroots recovery advocacy organizations rose in the late 1990s, mirroring the earlier rise of local alcohol and drug councils in the 1960s and 1970s. At the same time, many of the local affiliates of the National Council on Alcoholism and Drug Dependence (NCADD)

sought to revive their historical missions following the realization that operating large, complex service organizations had diverted them from their original mission of public education and public policy advocacy. In the face of this awakening, the Johnson Institute used its Leadership Forum to launch the Alliance Project—the first effort to link these new and existing fledgling recovery advocacy groups into a national network. In 2000, the Alliance Project commissioned focus groups and a first-ever national survey of the recovery community by Peter D. Hart Associates, called The Face of Recovery.

In 1998 the Center for Substance Abuse Treatment's Recovery Community Support Program began providing seed money for local recovery advocacy efforts and continued that support until 2002, at which time its focus shifted to the development of peer-based recovery support services. As the new recovery advocacy movement gained momentum, other organizations such as the Legal Action Center offered support to address issues of stigma and discrimination.

In October 2001, more than 200 recovery advocates from 36 states met in St. Paul, Minnesota under the leadership of the Alliance Project to develop a national recovery advocacy campaign. Presentations at the 2001 recovery summit included addresses by two congressional leaders, Representatives Jim Ramstad and Paul Wellstone, who had been public about their own recovery experiences (Plate One). Emerging from the 2001 recovery summit was the Faces and Voices of Recovery campaign guided by an advisory committee made up of regional representatives of local recovery advocacy organizations. Early funding from the Johnson Institute and subsequent financial support from the Robert Wood Johnson Foundation and the Center for Substance Abuse Treatment allowed Faces and Voices of Recovery to hire its own staff and establish its independence as a nonprofit corporation in 2004 (see www.facesandvoicesofrecovery.org). At present, the recovery advocacy movement is led at a national level by a coalition of Faces and Voices of Recovery, the Johnson Institute, the Legal Action Center and NCADD. At a local level, the movement is represented by more than 125 recovery advocacy organizations and more than 8,000 self-identified core recovery advocates. During September 2006, more than 40,000 individuals and 45 sponsoring organizations participated in Faces and Voices of Recovery's Rally for Recovery education and celebration events (5).

Movement Goals The espoused 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 living role models that illustrate the diversity of those recovery solutions, 3) counter public attempt to dehumanize, objectify and demonize those with AOD problems, 4) enhance the variety, availability, and quality of local/regional treatment and recovery support services, and 5) remove environmental barriers to recovery by promoting laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems (4).

Core Values and Ideas The core values of this new generation of recovery advocacy organizations reflect a recognition of: 1) the primacy of personal recovery as a platform for political advocacy, 2) the need for authentic, grassroots recovery representation in the development of addiction-related policies and programs, 3) the importance of developing local and national recovery advocacy leadership, and 4) the value of cultural diversity, including representation of diverse pathways and styles of addiction recovery. Where earlier American social movements sought to alter public perceptions of and public policies toward those with AOD problems by redefining the problem ("alcoholism is a disease"), altering perceptions of those with the problem ("the alcoholic is a sick person") or promoting a particular intervention ("treatment works")(6, 7), the new recovery advocacy movement shifts the focus from the problem and the intervention to the solution (8, 4). The core messages that have

marked the earliest stages of this movement include the following:

1) Addiction recovery is a living reality for individuals, families and communities (see www.recoveryiseverywhere.org) (Plates Two and Three),
2) There are many (religious, spiritual, secular) pathways to recovery,
3) Recovery flourishes in supportive communities,
4) Recovery is a voluntary process, and
5) Recovering and recovered people are part of the solution: recovery gives back what addiction has taken from individuals, families and communities (4).

This new movement is also suggesting that recovering people, through their silence and invisibility, have been part of the problem (Plate Four). Stigma did not diminish for other health conditions (e.g., cancer) until a critical mass of citizens personally knew someone who was in recovery from these conditions. The new recovery advocacy movement is challenging a vanguard of individuals and families in long-term addiction recovery to step forward and announce their presence within the American culture and to organize themselves as a political force (Plate Five).

Core Strategies To date, there are eight major strategies of the new recovery advocacy movement:

1) *Building strong, grassroots recovery advocacy organizations and linking these organizations into a national movement* that offers opportunities for recovering people to express their collective voice and participate in community service projects (Plate Six).
2) *Advocating for meaningful representation and voice at policy levels* for people in recovery and their family members on issues that affect their lives (Plate Seven).
3) *Assessing needs* related to the adequacy and quality of local treatment and recovery support services.
4) *Educating the public, policymakers and service providers* about the prevalence and pathways of addiction recovery.
5) *Expanding human and fiscal resources* by encouraging philanthropic and public support for addiction treatment, recovery support services, and recovery advocacy and by cultivating volunteerism within local communities of recovery.
6) *Creating recovery support centers* that delivery non-clinical, peer-based recovery support services.
7) *Celebrating recovery from addiction* through public events (recovery marches, rallies, concerts) that offer living testimony of the transformative power of recovery (Plates Eight, Nine & Ten).
8) *Supporting research* that illuminates effective strategies and the processes of long-term recovery.

Diversity Another feature that distinguishes the emerging recovery advocacy movement from its predecessors is the diversity of ethnic communities, pathways and styles of recovery, and institutional settings (e.g., recovery ministries within churches, recovery schools) that it is embracing. This diversity is represented by such organizations as White Bison, Inc. (Plates Eleven & Twelve), the El Paso Recovery Alliance (Plate Thirteen), Recovery Consultants of Atlanta, SpeakOUT: LGBT Voices of Recovery, the National Alliance of Methadone Advocates (NAMA), and Advocates for Recovery through Medicine (ARM). There are also groups such as the Connecticut Community of Addiction Recovery that have built strong, multi-ethnic recovery advocacy coalitions, and there are regional advocacy alliances such as the New England Alliance for Addiction Recovery.

A growing number of people recovering from AOD problems are using their personal transformations as a platform to advocate social change related to the sources of and solutions to community-wide AOD problems. The new recovery advocacy movement in America is transforming people who have been the country's problems into instruments of social action and community service.

References

1. Tuchman B. *Practicing history*. New York: Alfred A. Knopf; 1981.

2. Johnson B. *The alcoholism movement in America: a study in cultural innovation* [dissertation]. Urbana, IL: University of Illinois; 1973.

3. Roizen R. *The American discovery of alcoholism, 1933-1939* [dissertation]. Berkeley: University of California; 1991.

4. White W. *Let's go make some history: chronicles of the new addiction recovery advocacy movement*. Washington, DC: The Johnson Institute; 2006.

5. Taylor P. *Faces and Voices of Recovery: where we started* [unpublished manuscript]. Washington, DC: Faces and Voices of Recovery; 2006.

6. Anderson D. Alcohol and public opinion. *Q J Stud Alcohol* 1942; 3(3): 376-392.

7. Mann M. Formation of a National Committee for Education on Alcoholism. *Q J Stud Alcohol* 1944; 5(2): 354.

8. White W. Treatment works: is it time for a new slogan? *Addiction Professional* 2005; 3(1): 22-27. Plates

Plate 1: Representative Jim Ramstad (at podium) and late Senator Paul Wellstone address the 2001 Recovery Summit (Courtesy Gabrielle Antolovich)

Plate 2: Recovery is Everywhere Campaign Poster (Courtesy of Dawn Farm)

Plate 3: Recovery is Everywhere Campaign Poster (Courtesy of Dawn Farm)

Plate 4: Silence Poster (Courtesy of Missouri Recovery Network)

Plate 5: Buttons and bumper sticker collected at recovery celebration events (Courtesy of Illinois Addiction Studies Archives)

Plate 6: Recovery Ambassadors Workshop (training for recovery advocates) (Courtesy of Johnson Institute)

Plate 7: Joel Hernandez alleges recovery job discrimination before the Supreme Court (Courtesy of Johnson Institute)

Plate 8: Local Recovery Celebration March (Courtesy of Connecticut Community of Addiction Recovery)

Plate 9: Recovery Advocates Meet at National Capital in 2005 (Courtesy Faces and Voices of Recovery)

Plate 10: 2005 America Honors Recovery Honorees: Tom McHale, Elizabeth Scott, Jerry Moe, James McClain, Stacia Murphy, Mark Helijas and Jay Davidson (Courtesy of Johnson Institute)

Plate 11: Wellbriety Movement Council of Elders members Horace Aztell (Nez Perce), Dr. Henrietta Mann (Cheyenne) and Ozzie Williamson (Blackfeet) at recent Wellbriety Conference (Courtesy White Bison, Inc.)

Plate 12: Wellbriety Hoop of 100 eagle feathers used in Wellbriety Celebrations (Courtesy of White Bison, inc.)

Plate 13: Member of Circulo de Hombres performs at a recovery celebration in El Paso, Texas (Courtesy El Paso Recovery Alliance)

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

NORTHEAST attc
The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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



The Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

© 2006

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.

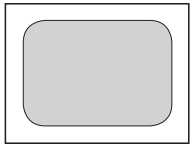
Citation of the source is appreciated. Do not reproduce or distribute this publication for a fee without specific, written authorization from Northeast Addiction Technology Center, NeATTC. For more information on obtaining copies of this publication, call 1.866.246.5344.

Visit

www.ireta.org

to download compendium PowerPoint® Presentation:

LINKING ADDICTION TREATMENT & COMMUNITIES OF RECOVERY: A PRIMER FOR ADDICTION COUNSELORS AND RECOVERY COACHES



YES! I would like to receive Training Brochures, Email list serve and other informational materials. Call or send the form below:

IRETA
Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219

412.391.4449 phone
412.391.2528 fax

Info@ireta.org
www.ireta.org

NAME: _____

AGENCY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

E-MAIL: _____



INSTITUTE FOR RESEARCH, EDUCATION
AND TRAINING IN ADDICTIONS

confronting problems...

developing solutions...

sharing knowledge...

transforming lives...

IRETA

Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219

412.391.4449 phone
412.391.2528 fax
Info@ireta.org
www.ireta.org

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.

Table of Contents

Preface i

Introduction and Acknowledgments 1

A Note on Language 4

A Special Note to Administrators and Supervisors 4

Historical Background: Toward a Recovery Paradigm 5

- From Problem Conceptualization to Treatment Strategies 5
- The Varieties of Recovery Experience 6
- Emerging Movements 6
- Toward a Recovery Paradigm 6
- Implications for the Addictions Counselor and Recovery Coach 7

Scientific Background, Post-Treatment Outcomes, Role of Continuing Care, Role of Recovery Mutual Aid Participation, Importance of Post-Treatment Check-ups and Support 9

American Communities of Recovery: A Brief Introduction 15

- A Long and Rich History 15
- Varieties and Commonalities 15
- Unanswered Questions 18
- Mutual Aid Critics 19
- The Choice Philosophy 19
- Choice and Limited Resource Alternatives 21

Building Relationships between Treatment Organizations and Local Communities of Recovery 23

- Linkage Philosophy 23
- Goals of Linkage Process 25
- Measurable Benchmarks 26
- Working with Mutual Aid Service Structures 27
- Encouraging Staff Exposure and Participation in Local Recovery Support Groups and Internet-based Recovery Resources 28
- Developing Recovery Volunteer Programs 28
- Developing or Renewing Recovery (Alumni) Associations 29
- Developing Formal Peer-based Recovery Support Programs 30

The Process of Linking Clients/Families to Recovery Support Groups and Communities of Recovery 35
Traditional "Aftercare" versus Assertive Approaches to Continuing Care 35
Building a Long-term Recovery Support Relationship 36
Competing with the Culture of Addiction 36
Linkage Steps 37
When Few Recovery Support Resources are Available 41
Steps to Expand the Variety of Recovery Support Groups 42
Providing Long-term Recovery Management 43
A Brief Note on Early Re-intervention 45
Styles of Long-term Recovery Mutual Aid Affiliation 45
Linkage Skills: A Brief Review 46
Summary 47
References 47
Appendix A: Resources to Contact about How to Organize a Recovery Community Center 55
About the Authors 56
Recovery-related Studies / A Selected Bibliography 57

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.

---

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

---

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.

---

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.

---

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.

---

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,

---

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]

---

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.

---

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.

References

Alcoholics Anonymous (1982). *Twelve Steps and Twelve Traditions*. New York: A.A. World Services, Inc.

Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. *Psychology of Addictive Behaviors, 11*(4), 308-323.

Anthony, W., Gagne, C., & White, W. (in press). Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal*.

Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery Without Treatment*. Philadelphia, PA: Temple University Press.

Borkman, T. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment, 15*(1), 37-42.

Broffman, T., Fisher, R., Gilbert, B., & Valentine, P. (in press). Telephone recovery support & the recovery model. *Addictions Professional*.

Chappel, J. N. (1993). Long-term recovery from alcoholism. *Psychiatric Clinics of North America, 16*(1), 177-187.

Coyhis, D. (2000). Culturally specific addiction recovery for Native Americans. In J. Krestan (Ed.), *Bridges to Recovery* (pp. 77-114). New York: The Free Press.

Dakis, C., & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience, 8*(11), 1431-1436.

Dawson, S. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction, 100*(3), 281-292.

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.

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment, 28*(Supplement 1), S51-S62.

Dennis, M. L., Scott, C. K., & Hristova, L. (2002). The duration and correlates of substance abuse treatment careers among people entering publicly funded treatment in Chicago [Abstract], *Drug and Alcohol Dependence, 66* (Suppl. 2), 44.

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.

Donovan, D. (1998). Continuing care: Promoting maintenance of change. In W. R. Miller, & N. Heather (Eds.), *Treating Addictive Behaviors* (2nd ed., pp. 317-336). New York: Plenum Press.

Else, D. (1999). Recovering recovery. *Journal of Ministry in Addiction And Recovery, 6*(2), 11-23.

Emrick, C. D. (1989). Alcoholics Anonymous: Membership characteristics and effectiveness as treatment. *Recent Developments in Alcoholism, 7*, 37-53.

Emrick, D. C., Tonigan, J. S., Montgomery, H. & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. McCrady and W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp. 41-78). Brunswick, NJ: Rutgers Center of Alcohol Studies.

Flaherty, M. (2006). *A Unified Vision for the Prevention and Management of Substance Use Disorders Building Resiliency, Wellness and Recovery (A Shift from an Acute Care to a Sustained Care Recovery Management Model).* Pittsburgh, PA: Institute for Research, Education and Training in Addictions (IRETA).

Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse, 25*(1), 93-116.

Fiorentine, R., & Hillhouse, M. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment, 18*(1), 65-74.

Forman, R. F. (2002). One AA meeting doesn't fit all: 6 keys to prescribing 12-step programs. *Psychiatry Online, 1*(10), 1-6.

Fransway, R. (2000). *12-Step Horror Stories*. Tucson, AZ: See Sharp Press.

Gilliam, M. (1999). *How A.A. Failed Me*. New York: William Morrow.

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.

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment*. New York, NY: New York University Press.

Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among the National Drug Abuse Treatment Outcome Study. *American Journal of Drug and Alcohol Abuse 25*(3), 385-406.

Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(3), 1-16.

Hser, Y., Grella, C., Chou, C. & Anglin, M. D. (1998). Relationship between drug treatment careers and outcomes: Findings from the National Drug Abuse Treatment Outcome Study. *Evaluation Review, 22*(4), 496-519.

Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*(5), 503-508.

Hubbard, R. L., Flynn, P. M., Craddock, G., & Fletcher, B. (2001). Relapse after drug abuse treatment. In F. Tims, C. Leukfield, & J. Platt (Eds.), *Relapse and Recovery in Addictions* (pp. 109-121). New Haven: Yale University Press.

Hubbard, R. L., Marsden, M. E., Rachal, J. V., Harwood, H. J., Cavanaugh, E. R., & Ginzburg, H. M. (1989). *Drug abuse treatment: A national study of effectiveness*. Chapel Hill, NC: University of North Carolina Press.

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine, 21*(1), 54-60.

Humphreys, K., Mavis, B. E., & Stoffelmayr, B. E. (1994). Are Twelve Step programs appropriate for disenfranchised groups? Evidence from a study of post-treatment mutual help group involvement. *Prevention in Human Services, 11*(1), 165-180.

Humphreys, K., & Moos, R. (2001). Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? *Alcoholism: Clinical and Experimental Research, 25*(5), 711-716.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol, 58*(3), 231-238.

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., et al, (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment, 26*(3), 151-158.

Ito, J., & Donovan, D. M. (1986). Aftercare in alcoholism treatment: A review. In W. R. Miller, & N. Heather (Eds.), *Treating Addictive Behaviors: Process of Change* (pp. 435-452). New York: Plenum.

Jason, L. A., Davis, M. I., Ferrari, J. R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education, 31*(1), 1-27.

Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (in press). Communal Housing Settings Enhance Substance Abuse Recovery. *American Journal of Public Health.*

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*(6), 640-646.

Johnson, E., & Herringer, L. (1993). A note on the utilization of common support activities and relapse following substance abuse treatment. *Journal of Psychology, 127*(1), 73-78.

Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous Careers: Patterns of AA Involvement Five Years After Treatment Entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

Kelly, J. F., & Moos, R. (2003). Dropout from 12-step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment, 24*(3), 241-250.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life* NY: Ballantine Books.

Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. In T. McGovern, & W. White (Eds.), *Alcohol Problems in the United States: A Twenty Year Treatment Perspective* (pp. 5-40). New York: Haworth Press.

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

Lash, S. J. (1998). Increasing participation in substance abuse aftercare treatment. *American Journal of Drug and Alcohol Abuse 24*(1), 31-36.

Loveland, D., & Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development.* Posted at http://www.bhrm.org/guidelines/addguidelines.htm

Mäkelä, K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Bergmark, K., Kurube, N., et al. (1996). *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*. Madison: University of Wisconsin.

Mallams, J. H., Godley, M. D., Hall, G. M., & Meyers, R. J. (1982). A social-systems approach to resocializing alcoholics in the community. *Journal of Studies on Alcohol, 43*(11), 1115-1123.

McInerney, J. (1970). The use of Alcoholics Anonymous in a general hospital alcoholism treatment program. *Medical Ecology and Clinical Research, 3*(1), 22.

McKay, J. R. (2001). Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects. *Evaluation Review, 25*(2), 211-232.

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction, 100*(11), 1594-1610.

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.

McLellan, A. T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction, 97*(3), 249-252.

McLellan, A.T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

Mertens, J. R., Weisner, C. M., & Ray, G. T. (2005). Readmission among chemically dependent patients in private, outpatient treatment: Patterns, correlates and role in long-term recovery outcome. *Journal of Studies on Alcohol, 66*(6), pp. 842-847.

Miller, W., & Kurtz, E. (1994). Models of alcoholism used in treatment: contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol, 55*(2), 159-166.

Miller, W.R. & Munoz, R.F. (2005). *Controlling Your Drinking: Tools to Make Moderation Work for You*. New York: Guilford Publications, Inc.

Miller, W. R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press.

Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol, 62*(2), 211-220.

Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment, 12*(4), 241-246.

Moos, R. & Moos, B. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical & Experimental Research. 29*(10), 1858-1868.

Morgan, O.J. (1995a). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly, 12*(1), 59-71.

Morgan, O. J. (1995b). Recovery-sensitive counseling in the treatment of alcoholism. *Alcoholism Treatment Quarterly, 13*(4), 63-73.

Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse, 8*(1), 45-59.

Nealon-Woods, M., Ferrari, J., & Jason, L. (1995). Twelve Step program use among Oxford House residents: Spirituality or social support for sobriety? *Journal of Substance Abuse, 7*(3), 311-318.

Nicolaus, M. (2003). *Recovery by Choice.* Oakland, CA: LifeRing Press.

Office of Applied Studies. (2005). *Treatment Episode Data Set (TEDS): 2002. Discharges from Substance Abuse Treatment Services* (DASIS Series S-25 No. DHHS Publication No. (SMA) 04-3967). Rockville, MD: Substance Abuse Mental Health Services Administration. Retrieved from http://wwwdasis.samhsa.gov/teds02/2002_teds_rpt_d.pdf .

O'Brien. C. P., & McLellan, A. T. (1996). Myths about the treatment of addiction. *Lancet 347*, 237-40.

Riessman, F. (1965). The "helper-therapy" principle. *Social Work, 10*, 24-32.

Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990s. *American Journal of Community Psychology, 18*(2), 221-230.

Room, R. (1989). The U.S. general population's experiences of responding to alcohol problems. *British Journal of Addiction, 84*(11), 1291-1304.

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.

Scott, C. K., Foss, M. A., & Dennis, M.L. (2005). Pathways in the relapse-treatment-recovery cycle over 3 years. *Journal of Substance Abuse Treatment, 28*(Supplement 1), S63-S72.

Simpson, D. D., Joe, G. W., & Broome, K. M. (2002). A national 5-year follow-up of treatment outcomes for cocaine dependence. *Archives of General Psychiatry, 59*(6), 539-544.

Simpson, D. D., & Marsh, K. L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims, & C. Leukefeld (Eds.), *Relapse and Recovery in Drug Abuse* (NIDA Monograph 72, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

Smith, J. (2005). Commentary: Alcoholism and free will. *Psychiatric Times, 41*(4), 1-7.

Sobell, L. C., & Sobell, M. B. (1981). Frequent follow-up as data gathering and continued care with alcoholics. *International Journal of the Addictions, 16*(6), 1077-1086.

Sobell, M.B., Sobell, L.C., Bogardis, J., Leo, G.I. and Skinner, W. (1992). Problem drinkers' perceptions of whether treatment goals should be self-selected or therapist-selected. *Behavioral Therapy, 23*, 43-52.

Stout, R. L., Rubin, A., Zwick, W., Zywiak, W., & Bellino, L. (1999). Optimizing the cost-effectiveness of alcohol treatment: A rationale for extended case monitoring. *Addictive Behaviors, 24*(1), 17-35.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2002). *Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services.* (DASIS Series: S-17, DHHS Publication No. [SMA] 02-3727). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Tiebout, H. (1949). The act of surrender in the therapeutic process, with special reference to alcoholism. *Quarterly Journal of Studies on Alcohol, 10*, 48-58.

Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., Carroll, L., Repa, K., Martin, A., & Tracy, L. A. (2002). *AA participation 10 years after Project MATCH treatment: Preliminary findings*. Poster presentation, Research Society on Alcoholism, San Francisco, July.

Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol, 42*(7), 626-641.

Wesiner, C., Matzger, H., & Kaskutas, L. A. (2005). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. *Addiction, 98*(7), 901-911.

Weiss, R. D., Griffin, M. L., Gallop, R., Onken, L., Gastfriend, D. R., Daley, D., Crits-Christoph, P., Bishop, S., & Barber, J. (2000). Self-help group attendance and participation among cocaine dependent patients. *Drug and Alcohol Dependence 60*(2), 169-177.

White, W. (1996). *Pathways from the culture of addiction to the culture of recovery: A travel guide for addiction professionals* (2nd ed.). Center City, MN: Hazelden.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Presented at Recovery Community Support Program (RCSP) Conference, April 3-5, 2000. Retrieved July 31, 2004 from http://www.facesandvoicesofrecovery.org/pdf/toward_new_recovery.pdf.

White, W. (2001a). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly, 19*(4), 1-32.

White, W. (2001b). Pre-AA Alcoholic Mutual Aid Societies. *Alcoholism Treatment Quarterly 19*(1), 1-21. White, W. (2002). The treatment renewal movement. *Counselor, 3*(1), 59-61.

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15.

White, W. (2005). Recovery Management: What if we really believed addiction was a chronic disorder? *GLATTC Bulletin.* September, pp. 1-7.

White, W. (2006). *Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity*. Philadelphia, PA: Philadelphia Department of Behavioral Health.

White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly, 20*(3/4), 107-130.

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

White, W., & Hagen, R. (2005). Treatment, recovery, community: A call for reconnection. *Counselor, 6*(6), 52-56.

White, W., & Kurtz, E. (2005). *The Varieties of Recovery Experience*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W., & Nicolaus, M. (2005). Styles of secular recovery. *Counselor, 6*(4), 58-61.

White, W., & Sanders, M. (2004). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. Posted at www.bhrm.org and http://www.facesandvoicesofrecovery.org/resources/overview.shtml#publications

White, W., & Taylor, P. (in press). A new recovery advocacy movement. *Recovery Magazine.*

White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

Wilbourne, P., & Miller, W. (2003). Treatment of alcoholism: Older and wiser? *Alcoholism Treatment Quarterly, 20*(3/4), 41-59.

Zweben, J. E. (1986). Recovery oriented psychotherapy. Journal of Substance *Abuse Treatment, 3*(4), 255-262.

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
dandreas@waldenhouse.org
http://www.waldenhouse.org/

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).

Visit
www.ireta.org
to download compendium
PowerPoint® Presentation:

LINKING ADDICTION TREATMENT &
COMMUNITIES OF RECOVERY:
A PRIMER FOR ADDICTION COUNSELORS
AND RECOVERY COACHES

Sign up for our mailing list to receive Training Brochures, Email list serve and other informational materials. Contact IRETA at the address below.

ireta

Institute for Research, Education and Training in Addictions
Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219
412.391.4449 phone
412.391.2528 fax

Info@ireta.org
www.ireta.org

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).

Recovery Definition

White, W. & Kurtz, E. (2005). *The Varieties of Recovery Experience.* Chicago, IL: Great Lakes Addiction Technology Transfer Center; and (in press), *International Journal of Self Help and Self Care*.

White, W. & Scott, C. (Draft Manuscript) Addiction recovery: Its definition and conceptual boundaries.

Wilson, B. (1958). The next frontier: Emotional sobriety. *A.A. Grapevine*, January, pp2-5.

The Recovery Experience

Chappel, J. N. (1993). Long-term recovery from alcoholism. *Psychiatric Clinics of North America, 16*(1), 177-187.

Denzin, N. K. (1987). *The Recovering Alcoholic*. Newbury Park, CA: Sage.

White, W. (2000). Listening to Lazarus: The voices of America's first "reformed drunkards." *Contemporary Drug Problems*, 26:533-542.

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

Recovery Capital

Cloud, W. & Granfield, R. (1994). Terminating addiction naturally: Post-addict identity and the avoidance of treatment. *Clinical Sociology Review, 12*:159-174.

Cloud, W. & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions, 1*(1), 83-104.

Granfield, R., & Cloud, W. (1999). *Coming Clean: Overcoming Addiction Without Treatment*. New York, NY: New York University Press.

Granfield, R. and Cloud, W. (1996) The elephant that no one sees: Natural recovery among middle-class addicts. *Journal of Drug Issues, 26*(1):45-61.

Laudet, A.B., White, W.L., & Storey, G. (in press) Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*.

Toward a Recovery Paradigm

Anthony, W., Gagne, C., & White, W. (in press). Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal*.

Borkman, T. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment, 15*(1), 37-42.

Elise, D. (1999) Recovering recovery. *Journal of Ministry in Addiction And Recovery, 6*(2),11-23.

Morgan, O.J. (1995a). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly, 12*(1), 59-71.

Morgan, O.J. (1995b). Recovery-sensitive counseling in the treatment of alcoholism. *Alcoholism Treatment Quarterly, 13*(4), 63-73.

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15.

White, W. (2004a). Recovery: The next frontier. Counselor, 5(1), 18-21.

Zweben, J.E. (1986). Recovery oriented psychotherapy. *Journal of Substance Abuse Treatment, 3*, 255-262.

History and Status of Recovery Mutual Aid Societies

Christopher, J. (1988). *How to Stay Sober: Recovery without Religion*. Buffalo, NY: Prometheus Books.

Christopher, J. (1992). *SOS Sobriety: The Proven Alternative to 12-Step Programs*. Buffalo, NY: Prometheus Books.

Christopher, J. (1989). *Unhooked: Staying Sober and Drug Free*. Buffalo, NY: Prometheus Books.

Humphreys, K. (2004). *Circles of Recovery: Self-Help Organizations for Addictions*. Cambridge: Cambridge University Press.

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., et al, (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment, 26*(3), 151-158.

Kessler, R. C., Mickelson, K. D. & Zhoa, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy, 27*(3), 27-45.

Kirkpatrick, J. (1978). *Turnabout: Help for a New Life*. Garden City, NY: Doubleday and Company.

Kirkpatrick, J. (1981). *A Fresh Start*. Dubuque: Kendall/Hunt Publishing.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life.* NY: Ballantine Books.

Kishline, A. (1994). *Moderate Drinking*. Tucson, Arizona: See Sharp Press.

Kurtz, E. (1979). *Not-God: A History of Alcoholics Anonymous*. Center City, MN: Hazelden.

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

Riessman, F. (1965). The "helper-therapy" principle. *Social Work, 10*, 24-32.

Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990s. *American Journal of Community Psychology, 18*(2), 221-230.

Stone, B. (1997). *My Years with Narcotics Anonymous*. Joplin, Missouri: Hulon Pendleton Publishing Co.

White, W. (2004). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*,532-538.

White, W. (2001). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly 19*(1), 1-21.

White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.

Workgroup on Substance Abuse Self-Help Organizations (2003). *Self-Help Organizations for Alcohol and Other Drug Problems: Towards Evidence-based Practice and Policy*. (February 2003 Technical Report). SAMHSA.

Key Studies/Papers on Twelve Step Groups

Emrick, D. C., Tonigan, J. S., Montgomery, H. & Little, L. (1993). Alcoholics Annonymous: What is currently known? In B. McCrady and W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp. 41-78). Brunswick, NJ: Rutgers Center of Alcohol Studies.

Fiorentine, R. (1999). After drug treatment: Are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse, 25*(1), 93-116.

Fiorentine, R., & Hillhouse, M. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment, 18*(1), 65-74.

Humphreys, K., Mavis, B. E., & Stoffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services, 11*, 165-180.

Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous Careers: Patterns of AA Involvement Five Years After Treatment Entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

Mäkelä, K., Arminen, I., Bloomfield, K., Eisenbach-Stangl, I., Bergmark, K., Kurube, N., et al. (1996). *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*. Madison: University of Wisconsin.

Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment, 12*(4), 241-246.

Moos, R. & Moos, B. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical & Experimental Research. 29*(10), 1858-1868.

Morgenstern, J., Kahler, C. W., Frey, R. M. & Labouvie, E. (1996). Modeling therapeutic response to 12-step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse, 8*(1), 45-59.

Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology, 65*, 768-777.

Workgroup on Substance Abuse Self-Help Organizations (2003). *Self-Help Organizations for Alcohol and Other Drug Problems: Towards Evidence-based Practice and Policy*. (February 2003 Technical Report). SAMHSA.

Key Books/Studies on Twelve Step Alternatives

Connors, G. J., Dermen, K. H. & Duerr, M. (1992). SOS membership survey: Preliminary results. In J. Christopher (Ed.), *SOS Sobriety* (pp. 61-65). Buffalo, NY: Prometheus Books.

Galanter, M, Egelko, S. and Edwards, H. (1993) Rational Recovery: Alternative to AA for addiction? *American Journal of Alcohol and Drug Abuse, 19*(4):499-510.

Humphreys, K and Klaw, E. (2001) Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol 62*(4):528-532.

Kaskutas, L. (1992). Beliefs on the source of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems, 19*(4), 631-648.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life*. New York: Ballantine Books.

Kishline, A. (1994). *Moderate Drinking*. Tucson, Arizona: See Sharp Press.

Nicolaus, M. (2003). *Recovery by Choice*. Oakland, CA: LifeRing Press.

Trimpey, J. (1989) The Small Book. New York: Delacorte Press.

Linking Clients to Recovery Mutual Aid Societies

Forman, R.F. (2002). One AA meeting doesn't fit all: 6 keys to prescribing 12-step programs. *Psychiatry Online, 1*(10), 1-6.

White, W. & Kurtz, E. (in press). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC

Recovery Advocacy (New Recovery Advocacy Movement)

White, W. (2002). An Addiction Recovery Glossary: The Languages of American Communities of Recovery. Retrieved March 25, 2006 from http://www.facesandvoicesofrecovery.org/pdf/white_add-rec-glossary.pdf

White, W. (2005). Recovery Rising: Radical recovery in America. http://www.facesandvoicesofrecovery.org/pdf/white_RadicalRecovery.pdf

White, W. (2001) The Rhetoric of Recovery Advocacy. Retrieved March 25, 2006 at http://www.facesandvoicesofrecovery.org/pdf/rhetoric_of_advocacy.pdf

White, W. (2000). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy*. Presented at Recovery Community Support Program (RCSP) Conference, April 3-5, 2000. Retrieved March 25, 2006 from http://www.facesandvoicesofrecovery.org/pdf/toward_new_recovery.pdf

White, W., & Taylor, P. (in press). A new recovery advocacy movement. *Recovery Magazine*.

White, W. (2001) The New Recovery Advocacy Movement: A call to service. *Counselor 2*(6):64-67.

Recovery Prevalence & Demographics

Alcoholics Anonymous (2005). Survey profiles today's AA members. *About AA: A Newsletter for Professionals*, Fall, p. 1.

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.

Dawson, S. A., Grant, B. F., Stinson, F. S., Chou, P. S. Huang, B. & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction, 100*(3), 281-292.

Recovery (Public Perceptions)

Faces & Voices of Recovery (2001). *The Road to Recovery: A Landmark National Study on the Public Perceptions of Alcoholism and Barriers to Treatment*. San Francisco, CA: Peter D. Hart Research Associates, Inc./The Recovery Institute.

Recovery in Communities of Color

Caetano, R. (1993). Ethnic minority groups and Alcoholics Anonymous: A review. In B. McCrady and W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and Alternatives* (pp.209-231). New Brunswick, NJ: Rutgers Center of Alcohol Studies.

Coyhis, D. (1999). *The Wellbriety Journey: Nine Talks by Don Coyhis*. Colorado Springs, CO: White Bison, Inc.

Coyhis, D. (2000). *Culturally specific addiction recovery for Native Americans*. In: Krestan, J. (Ed.), Bridges to Recovery (pp. 77-114). New York: The Free Press.

The Red Road to Wellbriety. (2002). Colorado Springs, CO: White Bison, Inc.

Coyhis, D. and White, W. (2002) Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor 3*(5):16-20.

Coyhis, D. & White, W. (2006). *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery-The Truth about the Lie*. Colorado Springs, CO: White Bison, Inc.

White, W., and Sanders, M. (2004). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. Retrieved March 25, 2006 from http://www.facesandvoicesofrecovery.org/pdf/recovery_color.pdf

Frameworks of Recovery (Religious, Spiritual, Secular)

Badri, M. B. (1976). *Islam and alcoholism*. Tacoma Park, MD: Muslim Students Association of the U.S. and Canada.

Green, L. L., Fullilove, M. T. & Fullilove, R. E. (1998). Stories of spiritual awakening: The nature of spirituality in recovery. *Journal of Substance Abuse Treatment, 15*(4), 325-331.

Laudet, A, Morgen, K. & White, W. (in press) 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*.

White, W. (2004) Transformational Change: A Historical Review. *IN SESSION: Journal of Clinical Psychology, 60*(5), 461-470.

White, W. & Laudet, A. (2006). Spirituality, science and addiction counseling. *Counselor Magazine, 7*(1), 56-59.

White, W. & Nicolaus, M. (2005). Styles of secular recovery. *Counselor, 6*(4), 58-61.

White, W. & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor, 6*(5), 58-62.

Wilson, B. (1962). Spiritual Experiences. *A.A. Grapevine*, July, pp. 2-3.

Styles of Recovery Initiation & Natural Recovery

Bacchus, L, Strang, J, and Watson, P. (2000). Pathways to abstinence: Two-Year follow-up data on 60 abstinent former opiate addicts who had been turned away from treatment. *European Addiction Research, 6*(3),141-147.

Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery Without Treatment*. Philadelphia, PA: Temple University Press.

Cunningham, J. A. (2000). Remissions from drug dependence: Is treatment a prerequisite? *Drug and Alcohol Dependence, 59*(3), 211-213.

Cunningham, J. A., Lin, E., Ross, H. E., & Walsh, G. W. (2000). Factors associated with untreated remissions from alcohol abuse or dependence. *Addictive Behaviors, 25*(2), 317-321.

Cunningham, J., Sobell, L. Sobell, M. & Kapur, G. (1995) Resolution from alcohol problems with and without treatment: Reasons for change. *Journal of Substance Abuse, 7*(3), 365-372.

Fillmore, K. M., Hartka, E., Johnstone, B. M., Speiglman, R., & Temple, M. T. (1988). *Spontaneous Remission of Alcohol Problems: A Critical Review*. Washington, D.C.: Institute of Medicine.

Finney, J. & Moos, R. (1981). Characteristics and prognosis of alcoholics who become moderate drinkers and abstainers after treatment. *Journal of Studies on Alcohol, 42*(1), 94-105.

Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment, 24*(2), 161-167.

High Bottom. (1949). *A.A. Grapevine*, October.

Jorquez, J. (1983). The retirement phase of heroin using careers. *Journal of Drug Issues, 18*(3), 343-365.

Maddux, J. & Desmond, D. (1986). Relapse and recovery in substance abuse careers. In F. Tims & C. Leukefeld, (Eds.), *Relapse and Recovery in Drug Abuse*. (NIDA Monograph Series 72, pp. 49-72).

Miller, W. & C'de Baca, J. (2001). *Quantum Change: When Epiphanies and Sudden Insights Transform Ordinary Lives*. New York, NY: Guilford Press.

Miller, W.R. & Munoz, R.F. (2005). *Controlling Your Drinking: Tools to Make Moderation Work for You*. New York: Guilford Publications, Inc.

Schutte, K. K., Nichols, K. A., Brennan, P. L., & Moos, R. H. (2001). Successful remission of late-life drinking problems. *Journal of Studies on Alcohol, 64*(3), 367-374.

Simpson, D. D., Joe, G. W., & Broome, K. M. (2002). A national 5-year follow-up of treatment outcomes for cocaine dependence. *Archives of General Psychiatry, 59*(6), 539-544.

Simpson, D. D., & Marsh, K. L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims, & C. Leukefeld (Eds.), *Relapse and Recovery in Drug Abuse* (NIDA Monograph 72, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health, 86*(7), 966-972.

Sobell, L. C., Ellingstad, T., & Sobell, M. B. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addiction, 95*(5), 749-764.

Sobell, M. B., Sobell, L. C. & Toneatto, T. (1991). Recovery from alcohol problems without treatment. In N. Heather, W. R. Miller and J. Greeley (Eds.) *Self Control and the Addictive Behaviors* (pp. 198-242). New York: Maxwell Macmillan.

Toneatto, A., Sobell, L. C., Sobell, M. B., & Rubel, E. (1999). Natural recovery from cocaine dependence. *Psychology of Addictive Behaviors, 13*(4), 259-268.

Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. *Journal of Studies on Alcohol, 42*, 626-641.

White, W. (2004b). Transformational Change: A Historical Review. IN SESSION: *Journal of Clinical Psychology, 60*(5), 461-470.

Vaillant, G. E. (1979). Paths out of alcoholism. In *Evaluation of the Alcoholic: Implications for Research, Theory and Treatment* (Research Monograph No. 5, pp. 383-394). Rockville, MD: National Institute of Alcohol Abuse and Alcoholism.

Stages of Recovery

Biernacki, P. (1986). *Pathways from Heroin Addiction: Recovery Without Treatment*. Philadelphia, PA: Temple University Press.

Brown, S. (1985). *Treating the Alcoholic: A Developmental Model of Recovery*. New York: Wiley.

Larsen, E. (1985). *Stage II Recovery: Life Beyond Addiction*. New York, NY: HarperCollins Publishers.

Prochaska, J., DiClimente, C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9),1102-1114.

Shaffer, H. J. & Jones, S. B. (1989). *Quitting Cocaine: The Struggle Against Impulse*. Lexington, MA: Lexington Books.

Waldorf, D. (1983). Natural recovery from opiate addiction: Some social-psychological processes of untreated recovery. *Journal of Drug Issues, 13*(2), 237-80.

Recovery Durability/Stability

De Soto, C. B., O'Donnel, W. E. & De Soto, J. L. (1989). Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research, 13*(5),693-697.

Hser, Y., Hoffman, V., Grella, C. & Anglin, D. (2001) A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*(5), 503-508.

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*(6), 640-646.

Scott, C. K., Foss, M. A., & Dennis, M.L. (2005). Pathways in the relapse-treatment-recovery cycle over 3 years. *Journal of Substance Abuse Treatment, 28*(Supplement 1), S63-S72.

Medication Assisted Recovery

Murphy, S. and Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264.

Rychtarik, R. G., Connors, G. J., Demen, K. H. & Stasiewicz, P. R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol, 61*(1), 134-138.

White, W. & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor, 4*(5), 58-63.

The Culture of Recovery

Hollermanm L.K. & MacMaster, S.A. (2005). Applying a cultural competence framework to Twelve Step programs. *Alcoholism Treatment Quarterly, 23*(4), 107-120.

White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery: A Travel Guide for Addiction Professionals* (2nd ed.). Center City, MN: Hazelden.

Peer-based Recovery Support Services (Recovery Coaches, Recovery Housing, Recovery Schools)

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol, 58*(3), 231-238.

Jason, L. A., Davis, M. I., Ferrari, J. R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education, 31*(1), 1-27.

Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (in press). Communal Housing Settings Enhance Substance Abuse Recovery. *American Journal of Public Health.*

Loveland, D., & Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*. Posted at http://www.bhrm.org/guidelines/addguidelines.htm

White, W. (2004c). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Retrieved on September 19, 2005 from http://www.facesandvoicesofrecovery.org/pdf/peer-based_recovery.pdf

White, W. (2000) The History of Recovered People as Wounded Healers: I. From Native America to the Rise of the Modern Alcoholism Movement. *Alcoholism Treatment Quarterly. 18*(1)1-23.

White, W. (2000) The History of Recovered People as Wounded Healers: II. The Era of Professionalization and Specialization. *Alcoholism Treatment Quarterly. 18*(2):1-25.

White, W. (2001) Recovery University: The Campus as a Recovering Community. *Student Assistance Journal. 13*(2):24-26.

White, W. & Finch, A. (in press) The recovery school movement: Its history and future. *Counselor.*

Recovery in Women

Bischof, G., Rumpf, H., Hapke, U., Meyer, C. & John, U. (2000). Gender differences in natural recovery from alcohol dependence. *Journal of Studies on Alcohol, 61*(6),783-786.

Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among the National Drug Abuse Treatment Outcome Study. *American Journal of Drug and Alcohol Abuse 25*(3), 385-406.

White, W. (2002) Women, addiction, and recovery: A historical review. *Counselor 3*(4):52-54.

White, W. & Kilbourne, J. (in press). American women and addiction: A cultural double bind. *Counselor*.

Adolescent Recovery

Kandel, D. B. & Raveis, V. H. (1989). Cessation of drug use in young adulthood. *Archives of General Psychiatry, 46*(2), 109-116.

Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-step groups? A multivariate process model of effects. *Journal of Studies on Alcohol, 63*(3), 293-304.

Margolis, R., Kilpatrick, A., & Mooney, B. (2000). A retrospective look at long-term adolescent recovery: Clinicians talk to researchers. *Journal of Psychoactive Drugs, 32*(1), 117-125.

White, W. (in press) Recovery across the life cycle. *Alcoholism Treatment Quarterly.*

Family Recovery

Brown, S., & Lewis, B. (1999). *The Alcoholic Family in Recovery: A Developmental Model*. New York, NY: Guilford.

Rouhbakhsh, P., Lewis, V., & Allen-Byrd, L. (2004). Recovering Alcoholic Families: When is normal not normal and when is not normal healthy? *Alcoholism Treatment Quarterly, 22*(2), 35-53.

White, W. & Savage, B. (2005). All in the family: Alcohol and other Drug Problems, Recovery, Advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

Recovery Management & Related Studies

Broffman, T., Fisher, R., Gilbert, B., & Valentine, P. (in press). Telephone recovery support & the recovery model. *Addictions Professional.*

Dennis, M.L., Scott, C.K., Funk, R. & Foss, M.A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment, 28*, S51-S62.

Donovan, D. (1998). Continuing care: Promoting maintenance of change. In W. R. Miller, & N. Heather (Eds.), *Treating Addictive Behaviors* (2nd ed., pp. 317-336). . New York: Plenum Press.

Flaherty, M. (2006). *A Unified Vision for the Prevention and Management of Substance Use Disorders Building Resiliency, Wellness and Recovery (A Shift from an Acute Care to a Sustained Care Recovery Management Model)*. Pittsburgh, PA: Institute for Research, Education and Training in Addictions (IRETA).

Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(3), 1-16.

Institute of Medicine (2005) *Improving the Quality of Health Care of Mental Health and Substance Use Conditions: Quality Chasm Series.* Retrieved on March 25, 2006 from http://www.iom.edu/CMS/3809/19405/30836.aspx

McKay, J. R. (2001). Effectiveness of continuing care interventions for substance abusers: Implications for the study of long-term treatment effects. *Evaluation Review, 25*(2), 211-232.

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction, 100*(11), 1594-1610.

McLellan, A. T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction, 97*(3), 249-252.

McLellan, A.T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

O'Brien. C. P., & McLellan, A. T. (1996) Myths about the treatment of addiction. *Lancet 347*, 237-40.

Scott, C.K., Dennis, M.L. & White, W.L. (2004). Recovery management checkups: A future function of addiction professionals? *Addiction Professional, 2*(5), 33-39.

Stout, R. L., Rubin, A., Zwick, W., Zywiak, W., & Bellino, L. (1999). Optimizing the cost-effectiveness of alcohol treatment: A rationale for extended case monitoring. *Addictive Behaviors, 24*(1), 17-35.

Watkins, K., Pncus, H.A., Taniellan, T.L. & Lloyd, J. (2003). Using the chronic care model to improve treatment of alcohol use disorders in primary care settings. *Journal of Studies on Alcohol*, March, 2003, pp 209-218.

White, W. (2005). Recovery Management: What if we really believed addiction was a chronic disorder? *GLATTC Bulletin*. September, pp. 1-7.

White, W., Boyle, M. & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly, 20*(3/4),107-130.

White, W. & Sanders, M. (2004). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. Retrieved March 25, 2006 from http://www.facesandvoicesofrecovery.org/pdf/recovery_color.pdf

Evaluation of Recovery Management Models/Components

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.

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.

Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R. & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32.

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.



INSTITUTE FOR RESEARCH, EDUCATION AND TRAINING IN ADDICTIONS



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: Haberle, B & White, W. (2007) Gender-specific recovery support services: The evolution of the Women's Community Recovery Center. Posted at **www.williamwhitepapers.com**

Gender-specific Recovery Support Services: Evolution of the Women's Community Recovery Center to the Women's Recovery Community Center

Beverly J. Haberle, M.H.S., and William White, M.A.

Introduction

It was not long ago that addiction treatment and recovery was "a man's world". The treatment field's organizations were directed and staffed by men, served a primarily male clientele, and utilized theories and techniques drawn exclusively from male experience. Recovery support groups were similarly male-dominated, and women seeking entrance to them faced considerable obstacles to their recovery (White, 1996).

That world changed through the efforts of pioneering women whose lives are finally being celebrated (White, 2004). In the intervening years, we have learned as a field that there are important gender differences in almost every important dimension of addiction, treatment, and recovery (Kandall, 1996; Wechsberg, Craddock, & Hubbard, 1998; Walitzer & Dearing, 2006). These new understandings paved the way for gender-specific treatment programs and recovery support groups designed specifically for the needs of addicted women and their families (Schliebner, 1994; LaFave, 1999; Uziel-Miller, & Lyons, 2000; Kaskutas, 1994), and expanded the range of settings in which women with alcohol and other drug problems could be identified and served (Grella & Greenwell, 2004).

One limitation of the gender-specific service innovations of recent decades is that they have been developed inside an acute care model of addiction treatment that is ill-suited for women with high problem severity and complexity and low recovery assets. As a result, those calling for a shift in addiction treatment from an emergency-room model of brief biopsychosocial stabilization to a model of sustained recovery support are also arguing that this new model must meet the unique recovery support needs of women and people of color (White & Sanders, 2004). This shift to models of sustained recovery management is birthing new and renewed social institutions (e.g., peer-operated recovery support centers, recovery homes) and new and renewed service roles (e.g., recovery coaches, outreach workers). In spite of these advances, we are in the earliest stages of designing institutions and roles to meet the needs of recovering women.

The purposes of this article are to briefly describe the emergence of the recovery support center as a new indigenous service institution, profile the history and service components within the Women's

Community Recovery Center in New Britain, Pennsylvania, and highlight some of the lessons learned from the Center's first 18 months of operation.

Recovery Support Centers

There are a multitude of needs people experience over the course of their recovery from severe alcohol and other drug problems that are outside the traditional service scope of addiction treatment programs. The growing recognition of the need for non-clinical recovery support services is generating new models for delivering such services. One such model is the recovery support center (RCC). Usually operated by a grassroots recovery advocacy organization (Valentine, White, & Taylor, 2007)(see www.facesandvoicesofrecovery.org for a directory of such organizations), the RCC resembles the social fellowship of an AA clubhouse and the service orientation of a social service drop-in center. The Connecticut Community of Addiction Recovery (CCAR) describes its RCC as 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)

The development of regional RCCs in states like Connecticut and Vermont marks a new approach to the delivery of non-clinical recovery support services. 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 serves as a medium for connecting people with recovery needs to people with recovery assets." RCCs also function as "an organizational/human bridge between the professional treatment community and the recovery community" (White & Kurtz, 2006, p. 32).

Because of their service orientation, it would be easy to see the emerging RCCs as simply a new level of care within the existing treatment continuum of care, but RCC leaders reject such a view. They emphasize that what they are providing individuals is not treatment but recovery support services that are designed and delivered, not by clinically trained professionals, but by and for people in recovery. RCC leaders also emphasize that such services are part of their larger goal of developing recovery capital within local communities of recovery and the larger communities in which they are nested—an approach that blends individual and family support models with models of community organization and cultural renewal (McCarthy, 2006; Valentine, 2006).

History of the Women's Community Recovery Center

The Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) program was established in 1997 as a grassroots recovery advocacy organization. Its founding goals were to mobilize the members of the recovery community to reduce the stigma of addiction, to educate the public about addiction recovery, and to help shape pro-recovery public policies. In 1998, PRO-ACT received a Recovery Community Support Services Grant from the Center for Substance Abuse Treatment that provided the opportunity to expand PRO-ACT's role within the community and begin to provide peer driven / peer delivered recovery support services throughout Southeastern Pennsylvania. Through a highly participatory planning process, PRO-ACT has developed a wide variety of recovery support services designed to help individuals and families initiate and sustain long-term recovery and has extended the range of its service focus.

While PRO-ACT began in Bucks County, they have expanded their services to include the entire five-county Southeast Pennsylvania Region, with special focus on the City of Philadelphia. The latter move has been sparked by a recovery-focused behavioral health care systems transformation process being led by the Philadelphia Department of Behavioral Health (White, in press; see http://www.phila.gov/dbhmrs/strategicplanning/spi_re_intro.html).

One of the early projects developed by PRO-ACT was Mentor Plus (2000). The Mentor Plus project matched volunteer Mentors with inmates in early recovery ("Mentees") residing at the Bucks County Correctional Facility (BCCF). The Mentors visit their assigned Mentees once a week during the Mentee's incarceration. The focus of these visits was to develop a recovery plan that would be implemented upon the Mentee's release. As the program evolved, it became clear that female Mentees had a great deal more difficulty transitioning out of the institution and implementing a recovery plan than did their male counterparts. The special needs of female Mentees included safe housing, early financial assistance, recovery-conducive employment, assistance with family problems, support for continued education, and linkage for assistance and support for co-occurring medical and psychiatric illness.

At the same time these needs were being identified, another committee within PRO-ACT was exploring the Recovery Centers that were being established in Vermont and Connecticut. Out of that synergy of circumstances, PRO-ACT naively developed the idea of developing a Center that would combine the goals of providing recovery housing for women who needed it and providing a recovery–oriented, gender-specific sanctuary for other women in the community within this same facility. By this point, the Council had already had 15 years experience with gender-specific programming, outreach, and support working with women in a recovery community setting. In December of 2004, The Council purchased a building that once served as a women's college dormitory in New Britain, Pennsylvania for use as a Women's Community Recovery Center. The Center was opened to the Community in May of 2005 after months of work establishing a steering committee, fund-raising, attending zoning hearings, hiring staff, recruiting and training volunteers, and developing policies and service procedures.

Forty-eight volunteers were recruited and trained as program facilitators and recovery coaches, a 12 session Life Skills program curriculum was developed to address the barriers and needs that women seeking long-term recovery were most often experiencing. In January of 2006, with great excitement, the first 5 women entered the house as residents. Volunteers and professional staff worked together to continue outreach to the community while providing recovery support services to the residents. During 2006, the number of residents grew as the Center moved closer to their 18 person housing capacity.

Unfortunately, meeting the demand for housing quickly dominated The Center's efforts and became what seemed to be an overwhelming task. Screening potential residents and providing recovery support for those women living in the Center became the focus for both the staff and volunteers. As this occurred, the number of women living in the community and participating in the WCRC declined. In March of 2007, the staff began an evaluation process to review the experience to date of the Center. Peer volunteers, the staff, and the women who had participated, whether as members of the community or as residents, were involved in this evaluation process that resulted in several shifts in our approach to service delivery. In the remaining sections of this article, we will profile the women served by the Center, the core services of the Center, and the lessons we learned through this novel experiment of combining the provision of recovery housing and the delivery of non-residential recovery support services to women in the community within the same physical facility.

Profile of Women Residents

Over the past year and a half, 28 women, aged 19-47, have lived at the Women's Community Recovery Center (WCRC). These women presented with variable educational histories (7 without high school education, 13 with high school graduation or GED, 6 with some college work, and 2 college graduates), a history of unstable employment, and significant (25 of 28) legal involvement due to their past alcohol and other drug use. Multiple drug use was the norm among women residents, with only 5 of 28 women using just alcohol. Of the 28 residents served since January 2006, 9 were addicted to heroin and 14 to cocaine. All residents had received some level of drug and alcohol treatment prior to entering the WCRC, and some had multiple episodes of past treatment. 21 residents had prior involvement in a support group such as AA or NA before their admission to the WCRC. All residents had experienced more than one relapse, and many presenting with chronic relapse histories.

19 of the 28 residents were mothers, and another was pregnant at the time of her exit from the WCRC. These 19 mothers had a total of 47 children and 15 of the 19 had current or past custody problems or other serious parenting issues that had brought many to the attention of Children & Youth Services. 24 of the 28 residents came from a family where at least one (usually more) relative had a problem with alcohol or other drugs. In addition to the family of origin addiction histories, most residents were actively involved or had been involved in the past with a significant other who had a history of alcohol or other drug dependency.

22 of the residents reported physical health problems/diagnoses prior to admission. These problems ranged from Hepatitis C (10 out of 28 residents) to such problems as hypothyroid conditions, Hodgkin's Lymphoma (in remission), diabetes, arthritis, emphysema, asthma, hypertension/high blood pressure, anemia, herniated/degenerative discs, scoliosis, knee problems, kidney stones, dental issues, back pain, and migraines. 21 of the women had at least one psychiatric diagnosis, and 11 had more than one diagnosis at the time of their admission to the WCRC. The most prevalent diagnoses were depression, bipolar disorder, and anxiety disorders. Most of the residents reported prior psychiatric treatment, and most were taking medication for their psychiatric diagnoses during residency. They were often on more than one medication, with several of the residents taking psychiatric medications while being simultaneously enrolled in methadone maintenance therapy.

Several residents had experienced one or more inpatient stays at mental health treatment facilities. At the most extreme, one resident had been hospitalized for mental health concerns a total of 8 times with half of those admissions prompted by a suicide attempt. Other residents were/are under the care of a psychiatrist to manage their mental health symptoms, with most receiving psychiatric care through a local outpatient facility or through the psychiatrist at their drug and alcohol treatment program.

The majority of residents (22 out of 28) had a history of trauma prior to coming to the WCRC, with reported trauma ranging from childhood or adult physical, sexual, or emotional abuse; rape; witnessing violence; death of a child; and extreme neglect. Not only had many residents experienced sexual, physical, and/or emotional abuse or neglect as a child, but many also experienced various types of violence within their adult relationships, including physical and emotional abuse by partners as well as rape and sexual assault by partners and/or strangers.

It can be seen from this brief profile that the women admitted to residential recovery support presented histories of great severity, complexity, and chronicity, and in spite of their recent treatment histories, great acuity. The implication of this profile to the WCRC's self-assessment of its own capabilities will be discussed shortly.

WCRC Services

The women staying at the WCRC are expected to pay rent, but due to their poor financial status and difficulties in obtaining employment, many of the past residents left the WCRC owing rent money. Past residents have collectively paid $17,050 of a total of $23,000 due for rent, occurring during lengths of stay ranging from less than 2 weeks up to 40 weeks. The Center is staffed by 7 paid positions: a Women's Services Manager, a Volunteer Coordinator, a Case Manager, and four part time life skills support staff. All are recovery informed.[1] The Center currently has more than 20 volunteers. A case manager is made available to the residents in order to help them deal with the many problems residents experience navigating the traditional treatment system and in order to help identify and connect the residents with other community resources. Case managers and peer volunteer recovery coaches work with the residents to develop and implement recovery plans. Service activities in general include case management, recovery coaching, social support, education and skill building groups, and employment support. Center programming has expanded to include a monthly calendar, which is published and open to any woman in the community. Programming includes a lecture series, Life Skills workshops, Parenting, Craft/Cooking night, Bible Study, and presentations/discussions facilitated by volunteers on health and appearance.

Nearly all residents are enrolled in outside professionally-directed addiction treatment while living at the Center. These treatment services are provided by local provider organizations. While living at the WCRC, all residents are strongly encouraged to attend recovery support group meetings such as AA, NA, or Women for Sobriety. WCRC residents run their own AA meeting that is open to the community every Monday afternoon and evening at the Center, and they host a Wednesday morning AA meeting that provides babysitting services. The degree of connection between WCRC residents and the local recovery community and local support groups has varied from very strong to those who have never been engaged with the local recovery community.

One of the biggest challenges Center staff and volunteers have faced is how to provide true recovery support services instead of treatment services. Working with residents who present such a wide range and intensity of problems while living at the Center has a tendency to shift staff and volunteers out of their recovery support role toward a counseling role, which is unintended and inappropriate. The pull towards this clinical role is particularly strong in the face of relapse. Half of the residents (14 out of 28) experienced a relapse while in residency. Such relapse events often led to the exit of the client shortly thereafter, whether to a higher level of care, or the client leaving against staff advice. Where many residential treatment programs and recovery houses will administratively discharge clients who have relapsed, the WCRC staff and volunteers are willing to work with the client who relapses. While residency at the WCRC is not considered a level of treatment, the idea of working with a client who has relapsed and allowing her to remain in residence is a revolutionary one. For residents who relapsed, staff and recovery coaches together examined the situation to determine the best course of action, whether that meant facilitating a referral to a higher level of care for the client, or in helping the client develop a more effective relapse prevention plan. However, residents did not always respond positively to these staff efforts.

In its two years of operation, the WCRC was able to establish a residential recovery support center, recruit and train a

[1] By "recovery informed" we mean that they have a deep knowledge of the recovery process and the recovery community either through personal or family recovery experience or through other extensive contact with people in recovery.

core cadre of volunteers, develop a set of core services, establish a sound referral base, and engender strong local community support. Perhaps even more importantly, 22 out of 28 women obtained employment, 12 out of 19 mothers in residence began visitation with their children, all residents were linked to the local recovery community, 8 have remained involved with WCRC services after they left residence, and 3 are active volunteers working with other women seeking recovery.

The following three case studies further illustrate the characteristics of WCRC clients and WCRC recovery support services. (Names have been changed.)

> Marie is a 36 year old Caucasian female, single with one child with special needs. She has one older sibling, her parents are divorced, and her mother has remarried. She was referred through a local counseling center for residence. She presents as homeless, and is on prescribed Methadone as well as anti-depressant and sleeping medications. Marie is engaged in ongoing addiction and psychiatric treatment. During residence, she attended the 12 week life skills program, attended 12 Step meetings, and engaged with a Recovery Coach and a 12 Step Sponsor. Marie was able to regain joint custody of her son, and successfully complete all of her Probation and Parole requirements. She also became gainfully employed and took herself off Medical Assistance. She displayed patterns of taking on roles of responsibility, becoming overwhelmed, then sabotaging herself. She opted to take a career position and relocate to her parents' home despite staff and recovery coach feedback about this choice. She subsequently relapsed, but was able to return to treatment quickly and re-stabilize. She is currently working part time, and is actively involved in WCRC Services, Life Skills, and volunteer activity at the WCRC, while she and her son are living with her parents.

Faye is a 28 year old Caucasian female, single with no children. She is the youngest of 5 children, and her parents remain married. She was referred through a local counseling center for residence. She presented as homeless with a past history of treatment for ADHD, but was not taking prescribed medications. She was actively engaged in addiction treatment and mental health services at the time of her entry into the WCRC. During residence, she attended programming activities, the 12 week life skills program, and 12 Step Meetings, and she also engaged with a Recovery Coach and a 12 Step Sponsor. She entered the WCRC with private insurance and was unemployed. Faye achieved employment in retail, despite a college degree. She maintained the same job throughout her stay of 18 weeks. She completed the program successfully and moved on to rent a room from a woman in the Recovering Community. Faye continues to be involved in ongoing activities at the WCRC. She currently works in sales and was able to pass a State credentialing test with support from her recovery coach. She manages her ADHD through biofeedback rather than medication. She has maintained abstinence since her discharge.

Hope is a 26 year old Caucasian female, single with 2 children. She is the youngest of three children, her parents are divorced, and her father has remarried. She was referred through the prison (Bucks County Correctional Facility) for residence. Hope presented as homeless and with a history of Bipolar Disorder treated with a prescribed mood

stabilizer. She became actively involved in addiction treatment and mental health services through a local counseling center. During residence, she attended all of the WCRC's service programs and became actively involved in a 12 Step Program. Hope achieved employment during residence. Through the WCRC, she became involved with Bucks County Opportunity Council's self sufficiency program to seek financial assistance. She rented an apartment in the area, and continues to be employed. She recently received scholarships through the Bucks County Office of Opportunity as well as the Bucks County Chamber of Commerce for Beauty School, which she began in June 2007. She has maintained abstinence and continues to be actively involved in ongoing activities at the WCRC.

The following are case histories of women living in the community who have accessed and received services through the Center's Community component (names have been changed):

Elizabeth is a 40 year old woman recently arrested for her second DUI. Her longest period of abstinence was 7 years. Her last DUI was 9 years ago. She is a married mother of two teenagers, and a victim of rape and sexual abuse. Elizabeth first came to the Center as a result of her DUI. She has not had positive experiences with AA. She was matched with a Recovery Coach and attended the Life Skills Series as well as the Reading Group at the Center. She began to volunteer and attend AA. She got a sponsor, but relapsed on pain medication, and was a victim of violence during her relapse. She was admitted to a 14-day inpatient rehab. Within one week, she was transitioned into outpatient treatment. She met with her Recovery Coach weekly, who provided support with advocacy, support in helping connect with resources, and coaching with day to day problems with family and work. Elizabeth currently has nine months of recovery and growth. As she states, "The Center is a place where I am comfortable talking about things I don't talk about anywhere else-I really look forward to meeting with my Coach. We laugh and cry together. If it hadn't been for the folks at the Center, I don't know if I could have survived the relapse."

Cara is a 49 year woman facing severe liver failure. Cara connected with the Center through a local hospital. Initial involvement included home visits from the staff and volunteers from the Center. Cara had been in inpatient treatment four times over the past 10 years. She was a recently divorced mother of 2 adult children. She was matched with a Recovery Coach who helped Cara develop a recovery plan, and she attended lectures at the Center as well. However, she stated that she did not feel a part of the Center because she did not live there. Cara relapsed and died of liver failure. Her death raised a lot of questions and provided an opportunity to look at how the Center could better respond to those living within the community.

Lisa is a 52 year old woman with 3 adult children. She works as a waitress, and connected with a Recovery Coach. They developed a recovery plan which included ongoing meetings with her recovery coach. She received outpatient counseling and attended AA meetings as well as the Life Skills sessions at the Center. Her participation has become greater at the Center, as she has increased the number of activities she attends.

In addition, she volunteers one day per week at the Center.

Lessons Learned

The WCRC was founded on the belief that gender-specific recovery support services could be combined with professionally-directed treatment services to enhance long term recovery outcomes. After two years, we still believe in the importance of such services, but we have learned many lessons about the challenges of implementing and sustaining such services. In reviewing our experiences of the past 24 months, the following are among the most important of such lessons.

The Planning Process: It is important to note that, initially, as staff and volunteers moved through the developmental stages of the WCRC, they utilized a community development and empowerment model. The key word was inclusion: inclusion of the community via volunteers and inclusion of service recipients in the refinement of services over time. The WCRC relied extensively on volunteers from the community to form the work groups that develop rules and structure for the residents, as well as to develop the life skill building workshop curriculum. Volunteers also met to develop committees for fundraising and décor/ Center maintenance. As the Center evolved, staff took on more of a leadership role, and needs of the residents overshadowed the community outreach engagement efforts. Part of what is important in considering future staffing for the Center is the fact that the focus is shifting more toward a community developmental model. We see knowledge of addiction and recovery as important for staff but not necessarily a background of clinical treatment experience.

Staff/Volunteer Recruitment, Training and Supervision: Effective recovery support services rest on the principle of continuity of contact in primary recovery support relationships over time. Achieving that continuity requires retention of staff and volunteers, which in turn requires a high level of technical and emotional support for their efforts. That support is best demonstrated by rigorous screening and selection, structuring orientation and on-going training programs, ready availability for consultations on difficult situations, and regular opportunities for staff and volunteer recognition.

Volunteer Risk Management: Actions that volunteers take or fail to take can jeopardize the future of the best recovery support programs. This risk can be minimized by performing background checks on all applicants to serve as volunteers[2], training volunteers in ethical decision-making, providing ethical guidelines for peer-based recovery support services, and through close supervision.

Role Clarity: The scope and severity of the problems experienced by women entering the WCRC challenged us to remain in our non-clinical recovery support roles. This required constant reminders to staff and volunteers that we were NOT counselors or therapists and that our job was not to fix problems but to facilitate recovery initiation and maintenance. This required significant attention in training and supervision.

Gender-specific Barriers to Recovery: The lack of family support, the multiple role demands, the lack of financial resources, the past criminal records, and their own identities as outsiders severely limited the choices and access to community services of the women served by the WCRC. The histories of trauma and the resulting patterns of emotional volatility and relationship instability further compromised the ability of these women to achieve stable recovery.

[2] A criminal background check is not intended to automatically disqualify people who have such a background (many people in long-term recovery with notable community service have such a background); the background checks are intended to screen out individuals who have an established pattern of predatory behavior who may be looking for new venues though which they can exploit vulnerable individuals.

This is not to say that recovery is impossible, but that it requires a more complex and enduring support process than we had anticipated.

Diversity: We have found that one of the most important dimensions in the delivery of recovery support services is a broad representation of pathways and styles of recovery among staff and volunteers. Ideally, people being served should be brought into contact with the full scope of such styles, including the 12 step community, faith-based recovery ministries, secular programs of recovery and those in medication-assisted recovery. That diversity should also be reflected in the age and ethnic composition of staff and volunteers.

Medication Management: We had not anticipated the number of women we would serve who would be on prescribed psychotropic medication. That discovery demanded our attention via assuring continuity of medication access (e.g., women medicated in jail but given no medication upon their release to enter the WCRC), procuring a safe to secure medications, establishing a medication log to track medication consumption, staff education on medications and side effects, and increased communication with prescribing physicians.

Facility Security: There were more security issues than we had anticipated, e.g., women trying to sneak out to visit boyfriends. Given the crucial importance of physical and psychological safety in the delivery of women's services, we were forced to heighten security via a curfew, the use of security cameras, and a key fob system.

Relapse Management: We were unprepared for the level of problem severity (and the accompanying in-residence relapse rate) of those we served. While we supported the philosophical position that our response to women who relapsed should be one of early re-intervention and support, this was hard to operationalize. Training of staff and volunteers about the chronic nature of severe drug dependence and the principles of long-term recovery management helped us sort through the best options in the face of such relapse incidents.

Use of Community Resources: The key to effective recovery support centers is aligning the power of local community resources in support of recovery initiation and recovery maintenance. It was very important for us to establish constant and consistent communication with outside agencies to help our residents access the services that they needed, as well as to help keep us up to date on changes in our participants' status with other community agencies.

Co-location of Services: The central question the WCRC has faced is this: Can a recovery home and a recovery support center co-exist within the same physical facility? Responding to the overwhelming needs of the WCRC residents and the limits imposed by the physical design of the WCRC facility have prevented significant community participation. After careful deliberation, the WCRC has devised several changes to improve our ability to serve women living in the community. We suspect if we remained on the current path that co-location would have resulted in doing one or the other function well but that it would be very hard to maintain a level of excellence in service to both women in residence and women in the community.

The Evolution of the Center

In January of 2007, Dr. Stacey Conway collected and analyzed data on the Center and its residents. A Study Committee was developed to review the results and make recommendations to ensure the Recovery Support needs of the community were being met. The major finding was that housing 18 women within the Center would not allow for the community component of the program to grow and meet the needs of community members. As a result of that finding, the Committee recommended that the WCRC:

- Change the name of the Center from "Women's Community Recovery Center" (WCRC) to "Women's

Recovery Community Center" (WRCC) to better reflect the mission and purpose of the facility.

- Reduce the number of women living in the Center to six.
- Make renovations to make the house property more appealing to members of the community.
- Adjust screening protocols for potential residential candidates to ensure that the level of services we offer meets the level of services they need.
- Develop a Vision Committee to steer the ongoing programming provided through the center.
- Everyone entering the center is personally welcomed and oriented to Center services and Activities.
- An outreach and marketing plan needs to be developed and implemented.
- Additional, sustainable funding sources need to be identified.
- Have Information Specialists on site to provide information, advocacy, referral, and recovery support to anyone participating in Center.

As we think about the future of the Center, we want to re-engage and re-energize the Volunteers and then establish a diverse, 10-member Vision Committee, facilitated by Dr. Stacey Conway, to steer the direction of the future programs, projects, and services available through the Community Center. Our goal is to continuously improve the availability of the Center to provide access to women from the community who want to access, strengthen, and sustain long-term recovery. We are continuously adjusting this pioneering model.

Summary

Calls to transform addiction treatment into "recovery oriented systems of care" are triggering new experiments in the delivery of pre-treatment, in-treatment and post-treatment recovery support services. Two such experiments involve the proliferation of self- or staff-managed recovery homes and the rise of recovery support centers. This paper describes the attempt of the Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) to operate a gender-specific recovery home and a recovery support center within the same facility in New Britain, Pennsylvania.

In its first two years of operation, the Women's Community Recovery Center (WCRC) served 28 women in residence while attempting to also offer recovery support services to women in the larger community. The needs of the women being served in residence were so great and so complex that responding to these needs consumed the majority of staff and volunteer resources. Some of the critical lessons learned from this experience include the importance of community and consumer involvement in the planning and implementation process, the necessity for boundary management between clinically-oriented treatment services and non-clinical recovery support services, the importance of volunteer training and support, and the value of assertively linking the women being served to local communities of recovery and other formal and informal resources in the community.

References

Grella, C.E., & Greenwell, L. (2004). Substance abuse treatment for women: Changes in the settings where women received treatment and types of services provided, 1987-1998. *The Journal of Behavioral Health Services & Research*, *31*(4), 367-383.

Kandall, S. (1996). *Substance and shadow: Women and addiction in the United States*. Cambridge, MA: Harvard University Press.

Kaskutas, L. (1994). What do women want out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of*

Substance Abuse Treatment, 11(3), 186.

LaFave, L.M. (1999). An argument for choice: An alternative women's treatment program. *Journal of Substance Abuse Treatment*, *16*(4), 345-352.

McCarthy, P. (2006). Personal Communication, Patty McCarthy, Executive Director, Friends of Recovery Vermont.

Schliebner, C. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment*, *11*(6), 511-515.

Uziel-Miller, N., & Lyons, J.S. (2000). Specialized substance abuse treatment for women and their children: An analysis of program design. *Journal of Substance Abuse Treatment*, *19*, 355-367.

Valentine, P. (2006). Personal communication Phil Valentine, Director, Connecticut Community of Addiction Recovery.

Valentine, P., White, W., & Taylor, P. (2007) The recovery community organization: Toward a definition. Posted at http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf

Walitzer, K.S., & Dearing, R.L. (2006). Gender differences in alcohol and substance use relapse. *Clinical Psychology Review, 26,* 128-148.

Wechsberg, W.M., Craddock, S.G., & Hubbard, R.L. (1998). How are women who enter substance abuse treatment different than men?: A gender comparison from the Drug Abuse Treatment Outcome Study (DATOS). In S.J. Stevens, & H.K. Wexler (Eds.), *Women and substance abuse: Gender transparency* (pp. 63-79); and *Drugs & Society*, *13*(2), 97-115.

White, W. (1996). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2004). Women who made (and are making) a difference. *Counselor, 5*(5), 25-29.

White, W.L. (in press). A recovery revolution in Philadelphia. *Counselor.*

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.

White, W., & Sanders, M. (2004). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. In White, W., Kurtz, E. & Sanders, M. *Recovery Management*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Acknowledgment: Stacey Conway, Ph.D., Julia Babij, M.S .and Maura Farrell assisted in the development of this article. Support for development of this article was provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

About the Authors: Beverly Haberle is Executive Director of the Bucks County Council on Alcoholism and Drug Dependence, Doylestown, PA.and Project Director for PRO-ACT. William White is a Senior Research Consultant at Chestnut Health Systems and a consultant for the Philadelphia Department of Behavioral Health and Mental Retardation Services.



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. (2009). A brief meditation on the authenticity and character of recovery community organizations. Posted at **www.williamwhitepapers.com**

A Brief Meditation on the Authenticity and Character of Recovery Community Organizations (January, 2009)

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Recovery community organizations and new recovery community support institutions (recovery community centers, recovery homes, faith-based recovery colonies, recovery schools, recovery industries, recovery ministries/churches, recovery cafés, etc.) are growing rapidly in the United States. There is also growth in federal, state and local government and foundation support for various recovery advocacy and peer support activities to organizations that may or may not have strong ties to local communities of recovery. This raises the question of the legitimacy or authenticity of organizations providing peer support services and how such legitimacy and authenticity can be maintained. There are no rules from on high cast in stone to define such characteristics, but there is an extensive body of historical experience (for more than two centuries) that offers some wisdom on this issue.

This historical legacy and current sentiments within grassroots recovery community organizations (RCOs) would suggest 10 characteristics that define authentic RCOs and that can help RCOs manage threats to their authenticity. Authentic RCOs are organized by and for individuals and families in recovery. Toward that end, they:

1. Assure recovery representation (maintain recovery representation greater than 50% at membership, board, and staff levels)

2. Assure recovery leadership (leaders are drawn from individuals and family members in recovery or allies vetted by communities of recovery; RCO is committed to peer leadership development activities)

3. Maintain singularity of purpose (focus is on addiction recovery as evidenced by their mission, core values, plans and activities)

4. Minimize problems of “double agentry” (people in key leadership roles do not also represent other institutional--ideological, political, financial-- interests that could undermine the mission of the RCO)

5. Seek diversification of funding (efforts are made to minimize the risk of colonization or corruption of organizational values by external authorities; funding is rejected that comes with requirements that would compromise service relationships and relationships with communities of recovery)

6. Focus on long-term recovery at personal, family and community levels (recovery viewed as a process of intrapersonal, interpersonal and environmental transformation)

7. Distinguish their roles (from recovery mutual aid fellowships, professional treatment agencies and other agencies within the alcohol and other drug problems arena)

8. Respect multiple pathways of long-term recovery (recognize the legitimacy of multiple pathways of recovery and the rights of individuals/families to choose those pathways that best fit their needs and values)

9. Cautiously collaborate with kindred organizations (while resisting affiliations that would compromise their autonomy, integrity and mission)

10. Are responsible stewards (places recovery-focused services over personal or institutional aggrandizement and profit)

www.attcnetwork.org/greatlakes

Peer-based Addiction Recovery Support

William L. White, MA

Great Lakes ATTC
Unifying science, education and services to transform lives.

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

City of Philadelphia dbhmrs
recovery | resilience | self-determination

Peer-based Addiction Recovery Support

History, Theory, Practice, and Scientific Evaluation

William L. White, MA

Great Lakes Addiction Technology Transfer Center

Philadelphia Department of Behavioral Health and Mental Retardation Services

Peer-based Addiction Recovery Support

History, Theory, Practice, and Scientific Evaluation

William L. White, MA

Great Lakes Addiction Technology Transfer Center

Philadelphia Department of Behavioral Health and Mental Retardation Services



Great Lakes
ATTC
Unifying science, education
and services to transform lives.



City of Philadelphia
dbhmrs
recovery | resilience | self-determination

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Dedication

This monograph is dedicated to:

Barbara Weiner and Rebecca Rowe of Hazelden Library, and to Stephanie Merkle and Christopher Roberts, research assistants at Chestnut Health Systems. This monograph was possible only through their tenacious efforts to procure hundreds of historical documents, scientific studies, trade journal articles, posted papers, conference presentations, and other unpublished manuscripts. Barbara, Rebecca, Stephanie and Christopher, and their counterparts around the country receive far less acknowledgment for their contributions to the field than they deserve.

Thomasina Borkman, for her pioneering work on experiential learning and peer-based recovery support organizations.

Those working on the front lines of peer-based addiction recovery support services. Thank you for opening your lives and your organizations to me.

Table of Contents

Welcome from Lonnetta Albright and Michael Flaherty, PhD 1
Foreword by Arthur C. Evans, PhD and Beverly J. Haberle, MHS 3
Abstract 7

Introduction
Summary of Key Points 9
The Recovery Management Monograph Series 9
Purpose of the Current Monograph 11
A Note on Language 12
A Caution to the Reader 12
Acknowledgments 13

Chapter One: Defining Peer-based Recovery Support Services
Summary of Key Points 15
Defining Peer Recovery Support 16
Distinguishing Professional and Peer Support 19
Core Characteristics of P-BRSS Specialists 22
Varieties of Peer Recovery Support Services 25
Core Functions 27
Treatment Adjunct or Alternative 29

Chapter Two: The History of Peer-Based Recovery Support Services
Summary of Key Points 31
Solo Practitioners 34
Peer Recovery Support and Religious/Cultural Revitalization Movements 35
Secular Recovery Mutual-aid Societies 36
Spiritual Recovery Mutual-aid societies 37
Religious Recovery Mutual-aid societies 37
Family-Focused Recovery Support Societies 38
Occupation-based Recovery Support Groups 38
Shared Characteristics of Recovery Support Groups 38
Recovery Support for Special Populations 39
- Gender-specific mutual-aid groups 39
- Age-specific recovery support 40
- Recovery mutual aid and advocacy in communities of color 40
- Recovery support for and within the LGBT community 41
- Recovery support for people with co-occurring disorders 41
- Recovery support for people embedded within the criminal justice system 41
- Recovery mutual aid in rural communities 42

Geographical Accessibility of Recovery Mutual-aid Groups 42
Internet-based Recovery Support 47
Recovery Community Service Institutions and Organizations 47
Recovery Social Clubs 48
Recovery Advocacy Organizations 49
Recovering People Working in Non-professional Support Roles in Addiction Treatment 50
Recovering People Working in Professional Roles in Addiction Treatment 53
Current Recovery Coaching Practices in the Public and Private Sectors 62

Chapter Three: The Theoretical Foundations of Peer-Based Recovery Support

Summary of Key Points....67
"Nothing about us without us"....69
The Wounded Healer Tradition....71
The Power of Calling (Amends in Action)....73
Experiential Knowledge....74
Chronic Illness and Peer Support....78
Charisma and Recovery....80
Spirituality and Recovery....84
Storytelling and the Power of Mutual Identification....85
Stigma and The Dynamics of Help-seeking....88
Sharing Recovery Capital....92
The Helper Therapy Principle....93
Individual, Community, Culture....94
Cultures of Addiction and Recovery....96
Preventing Harm in the Name of Help....97
Stewardship of Community Resources....99
The Threats of Anti-professionalism and Professionalism....100
Primacy of Personal Recovery and Importance of Self-Care....103
Role of Risk in Recovery....105
The Value of P-BRSS....105
Criticism of P-BRSS....107
Testing the Theoretical Foundations of P-BRSS....109

Chapter Four: Scientific Evaluation of Peer-based Support: Studies of the Effects of Participation in Recovery Mutual-aid Societies

Summary of Key Findings....113
Limited Scope of Research on Recovery Mutual-aid Societies....115
Role of Mutual Aid in Recovery Outcomes....117
Variability of Response....119
Effectiveness across Diverse Populations....120
Cost-effectiveness....125
The Question of Harm (Iatrogenesis)....126
Potent Ingredients of Recovery Mutual Aid....128
Additive Effects of Professional Treatment and Mutual Aid....130
Timing of Participation....131
Linkage Procedures and Participation Rates....132
Linking Adolescents to Recovery Support Groups....133
Early Drop-out Rates....134
Dose and Intensity of Participation Effects....136
Frequency of Participation....136
Duration of Participation....137
Role of Internet-based Recovery Support....138
Relationship between Helping and Helper Recovery Outcomes....139
Studies of Family Support Groups....140

Chapter Five: Scientific Evaluation of Peer-based Services: Studies of the Effects of Participation in other Recovery Community Institutions

Summary of Key Findings 145
Recovery Social Clubs 146
Recovery Community Centers 147
Recovery Homes 149
Recovery Colonies 154
Recovery Schools 155
Peer-based Occupational Recovery Support 158
Recovery Ministries/Recovery Churches 160
Other Recovery Support Structures 162

Chapter Six: Scientific Evaluation of Peer-based Services: Studies of Recovering People Working in Addiction Treatment

Summary of Key Findings 165
Science versus Stereotypes 166
Recovery Representation in Addiction Treatment 167
The Role Transformation of Addiction Counselors in Recovery 171
Demographic Profile of Counselors in Recovery 174
Prior Treatment/Recovery Experience of Counselors in Recovery 174
Pre-service Educational Functioning of Counselors in Recovery 175
Educational Levels of Recovering People Working as Addiction Counselors ... 175
Certification, Licensure, and Clinical Effectiveness 176
Compensation of Recovering Counselors versus Counselors Without a History of Addiction 178
Personality Characteristics of Recovering Addiction Counselors 178
Beliefs and Attitudes of Recovering Addiction Counselors 179
Attitudes and Behaviors of Recovering Counselors Related to Evidence-based Practices 184
Role Perceptions of Recovering Addiction Counselors 186
Recovery Status and Client Perceptions of Credibility and Effectiveness 186
Counselor Recovery Status and Therapeutic Alliance 188
Counselor Recovery Status and Ethical Decision-making 189
Counselor Recovery Status and Client Recovery Outcomes 191
Recovery Status and General Job Performance Factors 196
Vulnerability to Relapse among Counselors in Recovery 196
Influence of Recovery Status on Supervisory Relationships 197
Evaluation of Treatment Models Staffed by Recovering People 198
Evaluation of Recovery Volunteer Programs Linked to Addiction Treatment or Medical Treatment 202
Relevant Studies on Peer-based Services from Allied Fields 204
Commentary on Lack of Distinctive Findings 207

Chapter Seven: Recent Studies of Recovery Coaching and P-BRSS
Summary of Key Findings 209
The Recovery Community Services Program (RCSP) 209
The Access to Recovery (ATR) Program 211
Studies of Service Elements related to P-BRSS 213

Chapter Eight: A P-BRSS Research Agenda
Summary of Key Findings 217
Toward a Recovery Research Agenda 217
Communities of Recovery as Ethno-cultural Communities 218
Research on Recovery Mutual-aid Groups 220
Participation in Other Recovery Community Institutions 221
Recovery Representation in Professional Treatment 221
Person-specific Factors Affecting Recovery Outcomes 222
P-BRSS and Stages of Recovery 223
P-BRSS Service Roles 223
Service Ingredients and Recovery Outcomes 224
Interaction Between P-BRSS and Professional Treatment 225
P-BRSS and Family/Community Recovery Outcomes 226
Organizational Contexts and P-BRSS Outcomes 227
Concerns About P-BRSS 228

Chapter Nine: Summary and Conclusions 231
A Preview 235

Appendix
Table 12: Changing Recovery Representation in the Addiction Treatment Workforce 237

List of Tables

Table 1: Professional and Peer Models of Helping 20
Table 2: Defining Characteristics of P-BRSS 22
Table 3: Defining Characteristics of Organizations Delivering P-BRSS 26
Table 4: Geographical Dispersion of Addiction Recovery Mutual-aid Groups in the United States 43
Table 5: Paradigms of "Paraprofessional" and Professional Addiction Counseling 59
Table 6: Academic Theories on Mutual Peer Assistance 68
Table 7: Performance Measures and P-BRSS Core Ideas 109
Table 8: Demographic Characteristics of Recovery Mutual-aid societies 123
Table 9: Al-Anon Membership Characteristics in the United States, 1984 and 2006. 141
Table 10: Recovery Representation Among Counselors Working in Addiction Treatment: 1960-2007 168
Table 11: Concerns about P-BRSS Raised by Addiction Professionals, Treatment Administrators, and Members of the Recovery Community 228
Table 12: Changing Recovery Representation in the Addiction Treatment Workforce 237

Program Profiles

Program Profile 1: Peer Group Facilitation Training 47
(previously called “How to Start Your Own Self-help Group”)
Program Profile 2: PRO-ACT Philadelphia 48
Program Profile 3: Recovery Walk 2008 50
Program Profile 4 : Telephone Recovery Support 63
Program Profile 5: New Pathways Project 64
(Assertive Street and Community Outreach)
Program Profile 6: Recovery Advisory Committee 69
Program Profile 7: Recovery Foundations Training 70
Program Profile 8: Peer Leadership Academy 70
Program Profile 9: A New Day: A Celebration of Recovery 71
Program Profile 10: Amends in Action 74
Program Profile 11: Storytelling Training 88
Program Profile 12: Taking Recovery to the Streets 92
Program Profile 13: Vermont Recovery Center Network 148
Program Profile 14: Philadelphia Recovery Community Center 149
Program Profile 15: Recovery Home Survey 153
Program Profile 16: Connecticut Community of Addiction Recovery’s 153
Recovery Housing Project
Program Profile 17 : Recovery Oriented Employment Services 159
Program Profile 18: NET Consumer Council 163
Program Profile 19: Peer Specialist Initiative 170

Welcome

Lonnetta Albright, Executive Director
Great Lakes Addiction Technology Transfer Center

Michael T. Flaherty, PhD, Principal Investigator
Northeast Addiction Technology Transfer Center

We welcome you to this, the sixth effort in our monograph series designed to explore in depth the theoretical and practical aspects of peer-based addiction recovery support services and recovery-oriented systems of care. Once again, we have had the benefit of William L. White's expertise and passion in the conception and execution of this document.

After all the dedication, skill, and care that addiction professionals devote to our clients' well being, we all too often see our best work erode as fragile people return to the same circumstances and environments that fostered their illness. The peer-based recovery support model has arisen to nourish and protect the recovery that in many cases starts in professional treatment, and from the beginning William L. White has been one of its strongest champions.

As someone who has spent most of his career working toward the professionalization of the addiction treatment field—drawing the best from us and advocating the best *for* us—Mr. White is in a unique position to explore the value of services that extend beyond professional treatment. In his travels and studies, he has absorbed an encyclopedic knowledge of recovery systems and services, from potential to pitfalls.

In earlier documents, Mr. White and colleagues have explored the need to understand addiction's potential as a chronic illness requiring continuing care, the implications of recovery management for treatment systems and for the field as a whole, the critical role of professional treatment in initiating recovery, and the science—existing and recommended—that we need for better understanding and support of recovery. In this volume, he turns his attention to the peers who provide ongoing recovery support services before, around, and beyond professional treatment. To dispel the myths that say this model has not been tested or evaluated and is not supported by scientific evidence or the literature of our profession, the monograph provides 19 program profiles and includes more than 850 scientific and professional references.

As an added benefit of this exploration, Mr. White presents and clarifies two very distinct but complementary roles, that of the professional provider of treatment services and that of the peer providing recovery support services. People in these two roles might be thought of as working in partnership, sharing a common interest in the well being of the same individuals, guarding their medical safety, employing best practices, and promoting long-term recovery. Both roles are essential, and each completes the other. In many cases the exploration of these roles will not describe two distinct bodies of people, but

rather describe varying sets of skills that people use to guide their work, with some people combining skills from both roles.

It is our hope that addiction professionals and peer support providers alike will find this monograph valuable. May you find in it a little more clarity, many new ideas, a stronger sense of determination, and a far greater appreciation for the work that you and your counterparts do.

We wish to acknowledge and thank the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) for its ongoing support of these efforts and the opportunity to publish this important work. We also extend our gratitude to the Philadelphia Department of Behavioral Health and Mental Retardation Services, the Great Lakes Addiction Technology Transfer Center's partner in the publication of this document.

And our highest thanks go to our indefatigable author, William L. White. For the past 11 years, he has dedicated his life to seeing that this model—and the people whose lives depend upon it—have a chance for success. We are honored to do what we can to follow and support this quest.

Foreword

Arthur C. Evans, Jr., PhD, Director
Philadelphia Department of Behavioral Health and Mental Retardation Services

Beverly J. Haberle, MHS, Executive Director
Bucks County Council on Alcoholism and Drug Dependence

Bill White has once again given readers a wonderful opportunity to walk through history and learn the healing power that is unleashed when Communities of Recovery work together for the common good. This monograph provides a foundation for those newly engaged in peer-based addiction recovery support activities. It also creates an opportunity for those already involved in providing these services to expand their thinking by exploring the diverse and innovative varieties of peer-based activities that are emerging in the field.

In Philadelphia, as in much of the nation, we are currently witnessing a reawakening of hope, vision, and purpose, as stakeholders call for and strive to implement sweeping changes in the manner in which addictions services are delivered. These changes go far beyond developing new programs or tweaking the ways in which existing services are structured. Recovery transformation is about creating more holistic systems of care that are consistent with what both scientists and people in recovery tell us works. Transformation moves us beyond efforts at short-term stabilization to helping individuals achieve sustained recovery, find meaningful roles in their communities, and fulfill their highest potential.

This monograph can be used as a tool kit to guide the design and delivery of peer-based support services in the context of Recovery Oriented Systems of Care. Included in this work are cautions, questions of ethics, and areas for further exploration. It also provides reassurance and validation that the hard work and careful planning required to implement peer-based and peer-delivered services can pay off in remarkable ways. Sometimes the simplest gesture of kindness and support at the right time by a peer produces tremendous positive change.

This monograph provided for us an opportunity to walk down “memory lane” and reflect on what has transpired during the past few years within the City of Philadelphia. To say, “Recovery is alive and well in the City of Brotherly Love” is an understatement. Philadelphia’s recovery transformation process has employed a participatory, collaborative approach at all levels, including full engagement of local community members, including people in recovery, in strategic planning and program development. Individuals and families in recovery have contributed their time and talents to identify unmet needs, solve problems, provide trainings, put a positive face on recovery to reduce stigma,

and deliver one-on-one services. Collectively, these efforts are expanding opportunities for individuals to initiate and sustain long-term recovery.

The Program Profiles are a highlight of this Monograph. These profiles outline different types of peer-based activities, projects, and services. In doing so, they not only provide readers with opportunities to visualize what the services look like and to explore their potential benefits, but they also help promote the development of a learning community by providing contact information so that readers can access additional information about any particular activity. This is an invaluable resource for communities starting peer-to-peer services. Sometimes it is difficult to grasp how peer-based services and activities actually operate. Bill White's Program Profiles give readers a glimpse of actual services and allow them to benefit from others' experience in creating new roles and functions. It is a testimony to the hard work of all involved in the Philadelphia Recovery Transformation that fifteen of the Program Profiles describe activities occurring within the City of Philadelphia. This would not be possible if it were not for the forward-thinking members of the recovery community and the tremendous collaboration that they have had with city officials and providers. This monograph reinforces the importance of having a broad-based approach that addresses the implementation of peer support services from multiple perspectives.

From a system administration perspective, this work is enormously important. Bill White has long championed the need for the field to shift from a professionally directed, acute-care model, with its focus on isolated treatment episodes, toward a sustained recovery management approach. In doing so, he has contributed significantly to the sense of urgency and energy that is currently stirring in the field. In this new monograph, White lays another critical building block in the foundation of system-transformation efforts. He masterfully describes how peer-based recovery support services (P-BRSS) can be used prior to, during, and following acute treatment to achieve the fundamental goal of care: recovery and a meaningful life in the community for everyone. Equipped with this monograph, leaders of the recovery community, providers, policy makers, and system administrators—that is, all those who grapple with how to make the vision of recovery a reality—now have access to the burgeoning scientific evidence that supports the critical role of peer-based recovery support services in addiction recovery.

System administrators and policy makers will find this monograph to be an invaluable resource. In addition to being armed with the scientific rationale to inform their decision-making, they will also have a better understanding of the infrastructure supports that will be necessary to create a seamless continuum of integrated P-BRSS and treatment services. Currently, many stakeholders are keenly aware of the tensions that naturally emerge between P-BRSS specialists and addiction professionals as concerns regarding roles and credibility challenge efforts at collaboration. By outlining the rich history and tradition of peer support within the addiction field, White reminds all stakeholders of the unique contributions that peer-directed services offer. In addition, his vivid Program Profiles take the concept of collaborative P-BRSS and professionally directed services from the realm of abstract aspirations to that of concrete strategies.

Finally, White's recommendations regarding a research agenda for P-BRSS represent some of the most urgent challenges confronting the field. He argues that the current pathology-focused research agenda needs to be expanded to include an exploration of the factors that promote recovery. While the research base for P-BRSS continues to grow, there remain significant gaps in what is known about how people recover, and specifically the role of P-BRSS in supporting recovery. To be successful in transforming our service systems, we will need to build learning communities based on relevant research, trust, mutual respect, and an understanding that the goal of recovery is not just important for people with substance use challenges and their families. Rather, the hope and realization of recovery touches every individual, family, and organization in our community. In this, another seminal work, Bill White tears down the walls that have existed between those providing peer-based recovery support and those offering professional treatment and, in doing so, charts a course toward more effective care, and more sustained recovery, for all.

The genius of this work is that it simultaneously speaks to the broad range of stakeholders in the addictions field, from those in the recovery community who are inspired to "give back," to systems administrators who are seeking to ensure the highest possible standard of service delivery.

Abstract

Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation

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) to sustain one another and to help those still suffering. Formal peer-based recovery support services (P-BRSS) are now being delivered through diverse organizations and roles. The goals of this monograph are to 1) define P-BRS and P-BRSS, 2) present a brief chronology of P-BRS in the United States, 3) discuss the theories and principles that guide the design and delivery of P-BRS services, 4) illustrate the current varieties of P-BRSS, and 5) review the scientific studies that have evaluated P-BRS and specialized P-BRSS. The monograph closes with a discussion of the strengths and vulnerabilities of peer-based recovery support and professionally directed addiction treatment services.

Key Words: Recovery mutual aid, recovery support services, recovery-oriented systems of care, recovery management, paraprofessional, ex-addict, recovery coach, peer, guide, recovery community, communities of recovery, sponsorship, recovery homes, recovery schools, recovery ministries, outreach.

Recommended Citation: White, W. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

Introduction

Summary of Key Points

- 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 is seen in a 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—with *system* here defined as a macro-level organization of a community, state, or nation.
- This monograph reviews the history, operational principles, service practices, and scientific status of P-BRS and P-BRSS and their future relationship with professionally directed addiction treatment.

The Recovery Management Monograph Series

This is the seventh in a series of monographs on recovery management (RM) and recovery-oriented systems of care (ROSC). The first monograph, *Recovery Management*,[1] describes the emergence of recovery as an organizing paradigm for behavioral health services, reviews the varieties of recovery experience, outlines recovery management principles, and discusses recovery management within communities of color. The second monograph, *Special Report: A Unified Vision for the Prevention and Management of Substance Use Disorders*,[2] applies principles of chronic disease management to the treatment of severe alcohol and other drug (AOD) problems. The third monograph, *Linking Addiction Treatment and Communities of Recovery*,[3] details empirically grounded strategies for linking addiction treatment clients to indigenous communities of recovery. The fourth monograph, *Perspectives on Systems Transformation*,[4] is a

[1] White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management.* Chicago: Great Lakes Addiction Technology Transfer Center.
[2] Flaherty, M. (2006). *Special report: A unified vision for the prevention and management of substance use disorders.*
[3] White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.
[4] White, W. (2007). *Perspectives on systems transformation.* Chicago: Great Lakes Addiction Technology Transfer Center.

collection of interviews with federal, state, and local leaders who are pioneering ROSC. The fifth monograph, *Recovery Management and Recovery-oriented Systems of Care*,[5] defines and distinguishes recovery management and recovery-oriented systems of care, describes the changes in service practices that accompany the shift from acute care to sustained recovery management, and reviews the scientific evidence supporting the recovery management model. The sixth monograph, *Building the Science of Recovery*, outlines the scientific questions that must be answered to guide the future design of recovery-oriented systems of care.[6]

Collectively, these monographs portray an acute-care system of addiction treatment that has helped transform the lives of countless individuals and families, but whose potential benefits are often limited by serious design flaws. These design flaws can:

- inhibit client attraction, engagement, retention, and treatment completion;
- limit the scope and duration of professional services and recovery support provided during and following addiction treatment;
- fail to assertively link individuals and families to indigenous communities of recovery support;
- minimize the duration and intensity of post-treatment continuing care; and, as a result,
- generate high rates of post-treatment relapse and treatment re-admission.

Peer-based recovery support services (P-BRSS) are being designed to extend the current acute-care model of addiction treatment toward the singular goal of elevating long-term recovery outcomes. The strategies to achieve this goal broadly include pre-treatment, in-treatment, and post-treatment P-BRSS. Infrastructure support for these efforts include peer program standards development, peer training and certification initiatives, and regulatory changes that allow reimbursement of P-BRSS through Medicaid and Medicare and private managed behavioral health care entities.[7] These activities are a product of the broader interest in the use of "community guides" to lead marginalized individuals and families back into full participation in community life.[8]

---

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

[6] Laudet, A., Flaherty, M. & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.

[7] Goldstrom, I.D., Campbell, J., Rogers, J.A., Lambert, D.B., Blacklow, B., Henderson, M.J., et al. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(1), 92-103. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

[8] Davidson, L., Tondora, J., Staeheli, M., O'Connell, M., Frey, J., & Chinman, M. (2005). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community based clinical practice* (pp. 476-501). London: Oxford University Press. Loveland, D. & Boyle, M. (2005). *Manual for*

PURPOSE OF THE CURRENT MONOGRAPH

This seventh monograph provides a synthesis of current knowledge about the history, theoretical foundations, methods, and scientific status of peer-based recovery support services. This monograph is written primarily for those directly involved in planning, funding, delivering, supervising, and evaluating peer-based recovery support services. It is hoped that it will also find an audience among policymakers, purchasers of care, treatment program administrators, and addiction counselors and other service professionals. With such diverse readers, every effort has been made to present information in a clear and accessible language and to document meticulously the sources upon which conclusions and recommendations are based. The monograph introduces the reader to a lost body of literature on peer recovery support. I hope the unedited voices of these early pioneers will resonate with the contemporary reader. Program profiles are also included, most of them illustrating the varieties of peer recovery support services unfolding within one city (Philadelphia) as part of a larger recovery-focused behavioral health system-transformation process.

Also noteworthy is what is not included in this monograph. First, recovery advocacy as a medium of peer support is not addressed in this monograph because its recent history has been detailed in the author's book, *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*.[9] Second, by focusing on peer recovery support for those with the most severe and complex alcohol and other drug (AOD) problems, this monograph does not extensively address the role of family and peer support in resolving AOD problems of lower severity and duration that are often resolved without formal professional or peer recovery support services. Readers interested in the role of peer support in the resolution of subclinical AOD problems are encouraged to explore the growing literature on *natural recovery*, *spontaneous remission*, *maturing out*, *autoremission*, and *self-initiated change*.

---

recovery coaching and personal recovery plan development. Retrieved August 18, 2008 from http://www.bhrm.org/guidelines/RC%20Manual%20DASA%20edition%207-22-05.doc. Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, *49*(4), 550-561. White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor*, *5*(6), 20-22. White, W. (2006). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity*. Philadelphia, PA: Philadelphia Department of Behavioral Health.

[9] 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.

A Note on Language

The development of recovery-oriented systems of care for individuals, families, and communities experiencing severe alcohol and other drug problems rests on new ideas, new policies, and new service practices. The shift in focus from pathology and intervention to long-term recovery is generating a new language that fills the monographs in this series. Our work to-date rests on the belief that words are important. Great care has been taken in selecting and defining such terms as *recovery*, *family recovery*, *recovery management*, *recovery-oriented systems of care*, *recovery capital*, *pathways of recovery*, *styles of recovery*, *recovery priming*, and *recovery coaching*—to name just a few.[10]

The present monograph presents two key terms. *Peer-based recovery support*, which will be designated by the acronym P-BRS, is a broad term referring to any form of mutual assistance directed toward the goal of long-term recovery from alcohol and other drug problems. Such assistance can and often does occur informally, particularly within recovery mutual-aid societies. *Peer-based recovery support services*, which will be designated by the acronym P-BRSS, is a narrower term for assistance toward the same goal that is delivered through more specialized roles with more formal resources, service protocols, and safeguards. The key distinction here is the term *services*, which implies a more formal structure though which recovery support is delivered. Discussions of P-BRS will focus primarily on recovery support provided through recovery mutual-aid societies and abstinence-based religious and cultural revitalization movements. Discussions of P-BRSS will focus primarily on recovery support provided through recovery community organizations other than recovery mutual-aid societies and through addiction treatment programs and allied health and human service agencies.

A Caution to the Reader

There are many critical research questions about peer recovery support that have yet to be studied. Answers to-date for many questions are also tentative. This is a dynamic period in the development of these services. Caution is in order regarding the review of scientific studies of peer recovery support. Many of the cited studies suffer from methodological problems: convenient samples, small samples, lack of control groups and randomization, lack of follow-up, short periods of follow-up, and low follow-up rates, to name just a few. As with all research studies, the findings presented are best viewed as probationary, pending new studies of greater methodological sophistication.

---

[10] White, W. (2001/2002). The rhetoric of recovery advocacy; An addiction recovery glossary: The languages of American communities of recovery. 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.

Those on the front lines delivering peer support services and the individuals and families receiving these services do not have the luxury of waiting for needed studies. They must make the best decisions possible today based on what is now known. While this monograph seeks to convey present knowledge, it is crucial to recognize that this "best knowledge" is a living, evolving entity. Peer-based and other recovery support services, like professionally directed clinical services, are evolving in tandem with new scientific findings and the changing needs of those served. I look forward to the day when a fulfilled recovery research agenda will render this monograph obsolete.

Bill White
Senior Research Consultant
Chestnut Health Systems
Port Charlotte, Florida
January, 2009

Acknowledgements

Support for work on this monograph was provided by the Philadelphia Department of Behavioral Health and Mental Retardation and the Center for Substance Abuse Treatment's Great Lakes Addiction Technology Transfer. My thanks to those organizations and to two of their funding sources, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) and the National Institute on Alcohol Abuse and Alcoholism.

Jim Russell of Oklahoma Faces and Voices of Recovery assisted in locating surveys of recovery representation in the addictions treatment workforce and in updating membership profiles of recovery mutual-aid societies in the United States. Andrew Finch, Association of Recovery Schools, and Mandy Baker, Center for the Study of Addiction and Recovery at Texas Tech University, provided assistance in locating research on recovery schools. Paul Molloy provided critical background on the national network of Oxford Houses. Rod Funk of Chestnut Health Systems analyzed data on the changing recovery representation in the field and prepared the table displaying this change from 1970-2008. I am indebted to the following people for helping prepare the program profiles that illustrated the growing varieties of peer-based recovery support: Mark Ames, Eugenia Argires, Jennifer Dorwart, Ellen Faynberg, Bev Haberle, Michelle Khan, Joan King, Patty McCarthy, Seble Menkir, Tom O'Hara, Phil Valentine and Fred Way. The following individuals provided needed encouragement and helpful suggestions through the early drafts of this document: Ijeoma Achara-Abrahams, Lonnetta Albright, Mike Flaherty, Ben Bass, Brian Coon, David Dan, Ellen Faynberg, Tom Hill, Steve Hornberger, Keith Humphreys, Leonard Jason, Ben Jones, Merlyn Karst, John Kelley, Joan King, Seble Menkir, Garrett O'Connor, Lora Passetti, Fraser Ross, Mark Sanders, Jason Schwartz, Richard Simonelli, Laura Sklansky, and Pat Taylor. My

previous collaborations with Ernie Kurtz provided the foundation for this present work. I would also like to thank Pam Woll for lending her skilled touch to the final editing and layout of the monograph.

I offer particular thanks to Lonnetta Albright, Arthur Evans, and Mike Flaherty and their respective organizations: the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center. This monograph series is a testament to their sustained commitment and leadership in the development of recovery-oriented systems of care.

Chapter One

Defining Peer-based Recovery Support Services

Summary of Key Points

Peer-Based Recovery Support:

- 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 (for example, peer-owned, peer-directed, and peer-delivered).

Peer-Based Recovery Support Services:

- 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 time.
- P-BRSS may serve as an adjunct or alternative to professionally directed addiction treatment.

DEFINING PEER RECOVERY SUPPORT

There has been a recent proliferation of new forms of peer-based support to assist individuals and families in initiating and maintaining recovery from alcohol and other drug problems and enhancing the quality of personal/family life in long-term recovery. The advent of expanding sources of peer-based recovery support (P-BRS) and new roles specializing in the delivery of peer-based recovery support services (P-BRSS) calls for increased definition of these functions and roles. The following definition of P-BRS is offered as a starting point for discussion.

> *Peer-based recovery support is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.*

This definition contains several critical elements.

Peer-based means that the supports and services are drawn from the experience of individuals who have successfully achieved addiction recovery and/or who share other characteristics (for example, age, gender, ethnicity, sexual orientation, co-occurring disorders, prior prison experience, family experience, or other identity-shaping life experiences) that enhance the service recipient's sense of mutual identification, trust, confidence, and safety. What constitutes *peer* is defined by each individual, rather than by an organization. The reference to peer-*based* implies that services are provided by peers and that peers play an important role in the design, development, delivery, and evaluation of services. To further clarify this point, individuals seeking recovery may receive peer support within a therapy group led by a professional therapist within an addiction treatment organization, but this would not be considered a peer-based recovery support service.

Recovery support distinguishes the singular goal toward which all efforts are directed. *Recovery,* as used in this monograph, involves three critical elements: 1) sobriety (abstinence from alcohol, tobacco, and unprescribed drugs), 2) improvement in global health (physical, emotional, relational, and ontological—life meaning and purpose), and citizenship (positive participation in and contribution to community life).[11] *Support* involves the provision of informational, emotional, social, and/or material aid.

Process implies that the assistance is not a single event or activity and is relational rather than mechanical, and that continuity of support over the time is central to the desired outcome of long-term recovery.

---

[11] For discussions about the role of citizenship in recovery and the meaning of recovery, see: The Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228; White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

Non-professional means that the P-BRS relationship is closer to the reciprocity of friendship than the fiduciary relationship one has with a physician, lawyer, banker, psychologist, or social worker. The power differential in the relationship between peers is minimal compared to the power differential that characterizes professional service relationships. Many P-BRSS specialists are also *indigenous non-professionals,* meaning that they claim membership and are viewed as members of the group being served, and their activities are valued because of their personal history and social position within a constituent community.[12] P-BRSS specialists see those they serve, not as different from themselves, but as one of "my people"—"brothers and sisters" to whom they are connected by a "kinship of common suffering"[13] and a kinship of gratitude, hope, and shared purpose.

Non-clinical distinguishes P-BRS from clinical services that involve diagnosis and treatment by health care professionals. Addiction professionals and other professionals in recovery—christened "bridge people" by Bissell[14]—may volunteer to provide P-BRSS, but they are not acting in their professional capacity or providing professional services when they are in this role. Professional, clinically-based services may have a peer quality to them when they are delivered by physicians, nurses, psychologists, social workers, or addiction counselors who are in recovery. However, such services are not considered P-BRSS as defined in this monograph. *Non-clinical*, in addition to designating who is providing the service, also denotes what is being provided: the more general categories of informational, emotional, social, and instrumental (practical assistance such as transportation) support.[15] Two other distinctions are noteworthy. Where clinically oriented addiction treatment often values the experience of emotional catharsis, P-BRS extols the value of emotional control. Where clinically oriented addiction treatment services may focus inward on personal wounds, P-BRS involves a focus outward—on connecting with resources and relationships beyond the self.

The phrase *experientially credentialed* means that the knowledge drawn on to provide P-BRS is acquired through life experience rather than formal education. It is first hand rather than second hand. It means that peer support specialists understand long-term recovery as a "lived experience" and can offer

---

[12] Pearl, A. (1981). The paraprofessional in human service. In S. Robbin & W. Wagonfeld (Eds.), *Paraprofessionals in the human services*. New York: Human Science Press. Reiff, R. & Reissman, F. (1965). The indigenous nonprofessional: A strategy of change in community action and community mental health programs. *Community Mental Health Journal*, Monograph No. 1. Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, *49*(4), 550-561.

[13] Alcoholics Anonymous (1957). *Alcoholics Anonymous comes of age*. New York: A.A. World Services, Inc.

[14] Bissell, L. (1982). Recovered Alcoholic Counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

[15] Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, *27*(4), 392-401; Emerging peer recovery support services and indicators of quality: An RCSP Conference report, September 2006, Substance Abuse and Mental Health Services Administration.

guidance on the nuances of this experience as it unfolds over time. Their authority, sometimes referred to as "street credentials," comes from their own healing journey, their history of recovery service work with others, and their tenured membership within a community of recovering people. Most, but not all, persons providing P-BRS have experienced recovery personally or as a family member.

> *Experiential knowledge comes from having experienced, lived with, or done battle with addiction and from having participated in one's own or other's recovery. This does not explicitly require that all volunteer or paid support staff be recovered or recovering, but it does require that they have learned about addiction and recovery from close proximity. Experiential expertise requires the ability to use this knowledge to affect change in self or others. This latter credential—granted through the community "wire" or "grapevine" (community story-telling)—bestows credibility that no university can grant. It is bestowed only on those who offer sustained 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 own life history, character, relationships, and performance within the community.*[16]

Experiential knowledge does not mean that the P-BRSS specialist does not need training or supervision, but it does affirm life experience as the foundational source drawn upon in the helping process.

Assistance implies a broad spectrum of support activities—whatever it takes—rather than the more specialized service menus offered by professional helpers. Non-clinical, peer-based recovery support can be delivered through the framework of a recovery mutual-aid society or a community-based service or advocacy organization, or within a larger religious or cultural revitalization movement.

The phrases *long-term recovery* and *in initiating recovery, maintaining recovery, and enhancing one's quality of life in recovery* underscore the vision of P-BRSS as long-term availability and support, as opposed to brief, crisis-oriented biopsychosocial stabilization. The implicit focus is on moving beyond reducing addiction-related pathology to building sustainable personal, family, and community recovery capital. This is a vision of global health (wellness), life meaning and purpose, and enhanced service to community. It reflects the view that long-term recovery is far more than the alleviation of alcohol and drug problems from an otherwise unchanged life.

The phrase *from alcohol and/or other drug-related problems* defines the boundaries of experiential competence and suggests that the support services offered may not be appropriate for individuals and families experiencing problems outside this arena. It also conveys that P-BRSS encompass the whole

[16] White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

spectrum of AOD-related problems and not just those that meet criteria for severe alcohol or drug dependence.

In speaking of peer-based recovery support services (P-BRSS), the term *service* as used in this monograph will reflect a unit of activity provided by a formal helping institution rather than the "service work" that is a common dimension of personal recovery across religious, spiritual, and secular pathways of recovery. Peer-based recovery support (P-BRS) is used as an umbrella term for all forms of mutual recovery support, including those provided informally or through a recovery mutual aid group. Peer-based recovery support services (P-BRSS) will be used to designate those peer supports that are organized into formal services and delivered through more formal organizations. The distinction will be important as we later attempt to distinguish the recovery support provided by an addiction counselor or a 12-Step sponsor from that provided through the role of a recovery coach or other recovery support specialist.

DISTINGUISHING PROFESSIONAL AND PEER SUPPORT

Robert Emrick, a sociologist who has investigated peer support groups, notes the "natural antithesis between the philosophies of self-help and professional health care."[17] Emrick and others see several crucial differences between peer and professional models of support. Some of these key differences and the vulnerabilities resulting from them are briefly summarized in Table 1.[18] These represent generalizations about opposite models/philosophies that exist at either end of a long continuum. For any given individual or organization, actual modes of operation may lie anywhere along that continuum. However, an understanding of these two poles helps us understand some of the forces that have helped shape these services and the vulnerabilities they have created.

[17] Emerick, R.E. (1990). Self-help groups for former patients: Relations with mental health professionals. *Hospital and Community Psychiatry*, *41*(4), 401-407.

[18] This table is based on the work of the following: Emerick, R.E. (1990). Self-help groups for former patients: Relations with mental health professionals. *Hospital and Community Psychiatry*, *41*(4), 401-407.; Gartner, A.J. (1997). Professionals and self-help. *Social Policy*, *27*(3), 47-52; White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

.

Table 1: Professional and Peer Models of Helping

Helping Dimension	Professional	Vulnerability	Peer	Vulnerability
Source of Knowledge	Scientific knowledge presented in form of theories, empirical studies, and objective analysis.	Mistake knowledge gained from limited studies within a single paradigm for the whole truth.	Experiential knowledge drawn from historical and personal experience.	Mistake limited personal experience for the whole truth.
Control of Knowledge	Knowledge carefully controlled, often presented in arcane language, and protected.	Danger of closed ideological system investigating only questions that will not threaten the system and whose answers are already known; pathology-focused language contributes to social stigma.	Knowledge freely available and widely shared.	Anti-intellectualism; folk knowledge can be hijacked, corrupted, and commercialized by external institutions.
Role boundaries	Extreme separation of helper and helpee roles; emphasis on professional distance and objectivity.	Under-involvement; detachment and clinical abandonment.	Helper and helpee roles are reciprocal; emphasis on relational connection and personal involvement.	Over-involvement; injury to helpee and helper through excessive intimacy.

Helping Dimension	Professional	Vulnerability	Peer	Vulnerability
Structure of helping	Significant power differential between helper and helpee; extensive legal, regulatory, and ethical guidelines govern relationship; high external accountability; extensive record-keeping; limited accessibility; fees attached to services; considerable organizational hierarchy; helping as a commodity.	Helping procedures and personal and institutional interests can become more important than helping relationship and helping outcomes.	Minimum power differential between helper and helpee; helping relationship governed only by internal guidelines and group conscience; minimal if any records; low external accountability; high accessibility; services available without fees; minimal organizational hierarchy; helping as a commitment.	Exploitation of power inequities is possible in the peer context with no mechanisms for redress; over-extension of the helper; risk of organizational collapse; range of services limited by lack of financial resources.
Helping focus	Clinical orientation emphasizes "getting into oneself"; clinician is in control of degree of intimacy.	Approach can be personally invasive; tendency to define problems and solutions solely in personal rather than political or cultural terms.	Support focus is often on "getting out of oneself"—connecting with resources and relationships beyond the self; helpee controls degree of intimacy.	Those groups that emphasize politicizing their members may provide inadequate personal support.

It can be seen from this table that the differences between professional and peer models of helping are extensive. Steve Hornberger of the National Association for Children of Alcoholics suggests this professional/peer tension is similarly evident within efforts to move from provider-driven service models to family-driven service models.[19] Many reviewers of this monograph aptly noted that the distinctions between peer and professional models have blurred within the addiction field over the past four decades, and that this influence is reciprocal, with professional treatment exerting considerable influence on the content and style of recovery support meetings and recovery support fellowships exerting considerable influence on addiction treatment and addiction counseling. Such

[19] Steve Hornberger, personal communication, January, 2009; also see: Osher, W. and Osher, D. (2002). The paradigm shift to true collaboration with families. *Journal of Child and Family Studies*, 11(2), 47-60.

reciprocity of influence might be viewed as a healthy synergy or as a corruption and loss of the unique dimensions of both forms of helping.[20]

CORE CHARACTERISTICS OF P-BRSS SPECIALISTS

Looking at the ideal characteristics of a P-BRSS specialist (someone who provides P-BRSS) is one way to think about what distinguishes people providing these non-clinical services from outreach workers, case managers, or addiction counselors, as well as from recovery mutual-aid sponsors. The defining characteristics of P-BRSS are illustrated in Table 2. This Table further implies some of the potential differences between peer models of recovery support and professional models of addiction treatment.

Table 2: Defining Characteristics of P-BRSS

Role Dimension	Defining Characteristics of P-BRSS Specialist
Recovery Orientation	Focus on long-term recovery rather than brief biopsychosocial stabilization; focus on full recovery rather than remission; working across multiple (religious, spiritual, secular, cultural) frameworks of recovery rather than within a particular framework; emphasis on a person's self-determination and service philosophy emphasizing personal choice.
Strengths-based	Focus on individual strengths and enhancement of recovery capital via enmeshing individuals/families in a "culture of health" rather than focusing on disease and disability;[21] orientation toward potential rather than toward problems.[22]

[20] For concerns about negative influence of professional treatment on AA, see: Kurtz, E. (1999). *The Collected Ernie Kurtz*. Wheeling, WV: The Bishop of Books, pp. 131-141; For concerns about negative influence of AA on professional treatment , See Kalb, M. & Proper, M.S. (1976). The future of alcohology: Craft or science. *American Journal of Psychiatry*, *133*(6), 641-645.

[21] Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: a theoretical perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 134-41.

[22] Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.). *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman.

Role Dimension	Defining Characteristics of P-BRSS Specialist
Ecology of Recovery	Focus more interpersonal than intrapersonal; emphasis on building individual, family, and community recovery capital; assertive efforts to design and deliver family-focused P-BRSS.
Core Knowledge	Pathways, styles, and stages of long-term recovery; ecology of recovery; organizational structure, core ideas, language, and meeting rituals of local communities of recovery; service protocols of recovery community institutions; indigenous and formal support within larger community.
Core Skills	Engagement, motivational enhancement, recovery planning;[23] liaison with communities of recovery; assertive linkage between indigenous and formal recovery supports; lapse and relapse intervention; recovery education; recovery checkups and coaching; recovery resource development; reputation maintenance within communities of recovery; ability to access mainstream institutions; generalist rather than specialist role in recovery support.
Temporal Orientation	Focus on the present, next steps, and near future rather than focus on feelings about past personal experience.
Motivational Fulcrum	Hope-based rather than pain-based motivational strategies, attracting people to recovery based on what recovery can add to one's life rather than on what painful consequences can be escaped.
Use of Self	Strategic use of one's own story; making recovery contagious via energy and example; relating, not out of a position of expertise, superiority, or objectivity, but out of mutual identification and humility ("there but for the Grace of God go I");[24] striving for invisibility while deflecting praise and leadership opportunities to others in the community.
Service Vision	Long-term personal/family/community recovery; growth of individual/family/community recovery capital.

[23] See Borkman, 1998, for distinction between recovery planning and treatment planning. Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42.

[24] Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

Role Dimension	Defining Characteristics of P-BRSS Specialist
Roles of Professional Treatment and Community in Recovery	Professionalized services not viewed as the first line of response to need, but as a safety net for needs that cannot be met by natural community (relationships that are non-hierarchical, enduring, and non-financial); P-BRSS specialist immersed in community life; community invited to support individuals/families in recovery.
Community Education	Every opportunity used to educate the community about addiction recovery at personal, family, and community levels; shifts pathology-focused discussions within the community to solution-focused discussions; raises awareness of the approximately 90% of persons with AOD problems not seen in professional treatment.
Community Development	Role combines personal/family recovery support functions with recovery-focused community organization and cultural renewal/revitalization functions.
Advocacy	Assertive advocacy on recovery-related issues that transcend personal, professional, and institutional interests.; advocacy to reduce/eliminate service disparities; reduce/eliminate stigma/discrimination; and make addiction treatment more responsive, effective, and efficient.
Empowerment	Recovering people play key roles in governance of service organizations; emphasis on voluntary consent for participation in P-BRSS; choice and self-determination highly valued; P-BRSS role seen as non-hierarchical and catalytic rather than directive; support for advocacy on one's own behalf; linkage to recovery leadership development opportunities; self-monitoring to avoid "freezing clients in dependent roles."[25]
Degree of Personal Involvement	High degree of personal involvement: "There are things he [the indigenous nonprofessional] can do which the professional is not able to do and should not do.…He can be invited to weddings, parties, funerals and other gatherings—and he can go."[26]
Fidelity and Endurance	Continuity of contact with individuals, families, and community institutions over a sustained period of time.

[25] Dhand, A. (2006). The roles performed by peer educators during outreach among heroin addicts in India: ethnographic insights. *Social Science of Medicine*, *63*(10), 2674-85.

[26] Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

VARIETIES OF PEER RECOVERY SUPPORT SERVICES

P-BRSS are being delivered within a variety of organizational contexts, including recovery mutual-aid societies; addiction treatment programs; recovery community organizations; and allied health, child welfare, and criminal justice systems. These service-delivery organizations—spanning volunteer, not-for-profit, and for-profit entities—vary widely in their degree of connection to local communities of recovery.

Governance of organizations that provide recovery support involves control of organizational policies and the ways in which organizational assets are best invested to increase recovery outcomes. P-BRSS may be provided through:

- entrepreneur models in which excess assets of the organization are returned to private owner/investors in the form of profit,
- institutional models in which excess assets are reinvested in development of the organization, or
- recovery community development models in which excess assets are reinvested in projects that enhance the service work of local communities of recovery.

People performing P-BRSS roles are being variably referred to as sponsors, peer helpers, peer specialists, peer educators, peer mentors, outreach workers, residential managers, community guides, recovery coaches, recovery assistants, recovery support specialists, recovery escorts, recovery consultants, prosumers, recovery mentors, ombudsmen, and behavioral health paraprofessionals. While titles such as peer counselor or counseling aid are also sometimes used, they can be confusing because they heighten the level of ambiguity in the demarcation between professional treatment services and non-clinical recovery support services. As will be evident as we proceed through this monograph, it is important to distinguish clearly the roles of the P-BRSS specialist, the recovery mutual-aid sponsor, and the addiction counselor.[27]

Table 3 (following page) summarizes some of the key dimensions of peer recovery support and how these dimensions vary dramatically from organization to organization. We will return to some of these dimensions shortly for a more in-depth discussion.

[27] Clark, H.W. (1987). On professional therapists and Alcoholics Anonymous. *Journal of Psychoactive Drugs*, *19*(3), 232-42. Doyle, K. (1997). Substance abuse counselors in recovery: Implications for the ethical issue of dual relationships. *Journal of Counseling and Development*, *75*, 428-432. White, W. (2006). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity.* Philadelphia, PA: Philadelphia Department of Behavioral Health.

Table 3: Defining Characteristics of Organizations Delivering P-BRSS

Dimension	Varieties
Repsource Accrual and Allocation	A. Assets accrue as profits to owner(s)/investor(s) B. Assets are fed back into organization to support and expand support activities
Governance	A. Peers make major organizational decisions,, with accountability to one or more communities of recovery B. Peers can advise on organizational decisions; no accountability to communities of recovery C. Peers have no role in organizational decisions; accountability to communities of recovery
Problem Perception	A. Rooted in the person (Intrapersonal Model) B. Rooted in disturbed relationships (Interpersonal Model) C. Rooted in historical trauma/environmental conditions (Social Change Model)
Ideological Orientation	A. Religious B. Spiritual C. Secular D. Mixed
Method of Problem Resolution	A. Abstinence-based B. Moderation-based C. Medication-assisted
Relationship with Professionals	A. Professional Leadership (professionals serve as founders and group leaders) B. Professional Consultation (group is led by peers but has professionals available for consultation and support) C. Professional Collaboration Model (group is led by peers but works with other professionals in the community) D. No professional leadership E. Anti-professional
External Relationships	A. Closed System (thick organizational boundaries, aggressive gatekeeping, strict membership criteria to enhance mutual identification, isolation from community, expectation of confidentiality, anonymity at level of press) B. Open System (diffuse organizational boundaries, minimal gatekeeping, loose and evolving membership criteria, high levels of community interaction, leaders and members visible to larger community)
Internal Relationships	A. Face-to-face B. Telephone-based (voice and/or text) C. Internet-based D. Mixed
Service Roles	A. Peer support provided on a volunteer basis B. Peer support provided on a paid basis C. Peer support provided through a combination of volunteer and paid roles.

What distinguishes quality of peer recovery support services has been a focus of increasing discussion. In a 2005 meeting of the Center for Substance

Abuse Treatment's Recovery Community Services Program, 28 grantees defined 12 criteria they viewed as quality indicators.

1. Peer recovery support services are clearly defined in ways that differentiate them from professional treatment services and from sponsorship in 12-Step or other mutual-aid groups.
2. The programs and peer recovery support services are authentically peer based (participatory, peer led, and peer driven) in design and operation.
3. The peer recovery support program has well delineated processes for engaging and retaining a pool of peer leaders who reflect the diversity of the community and of people seeking recovery support.
4. The peer recovery support program has an intentional focus on leadership development.
5. The peer recovery support program operates within an ethical framework that reflects peer and recovery values.
6. The peer recovery support program incorporates principles of self-care, which are modeled by staff and peer leaders, and has a well considered process for handling relapse.
7. The peer program and peer recovery support services are nonstigmatizing, inclusive, and strengths-based.
8. The peer recovery support program honors the cultural practices of all participants and incorporates cultural strengths into the recovery process.
9. The peer recovery support program connects peers with other community resources irrespective of types of services offered.
10. The peer recovery support program has well established, mutually supportive relationships with key stakeholders.
11. The peer recovery support program has a plan to sustain itself.
12. The peer recovery support program has well documented governance, fiscal, and risk management practices to support its efforts.[28]

CORE FUNCTIONS

The functions of the P-BRSS specialist vary widely by role, clientele, and organizational setting, but collectively reflect the following functions:

- Assertive outreach to identify and engage those in need of recovery—what Malcolm X referred to as "fishing for the dead"[29] and Reiff and Riessman[30] called "reaching the hitherto unreached"

[28] Kaplan, L., *The role of recovery support services in recovery-oriented systems of care.* DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration, 2008, pp. 19-20.
[29] Myers, W.D. (1993). *Malcolm X: By any means necessary*. New York: Scholastic.
[30] Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*, Monograph No. 1.

- Minimization of harm to self, family, and community in the transitions through identification, engagement, destabilization of addiction, and recovery initiation
- Recovery capital/needs assessment for individual/family/community
- Recovery education and coaching for individual/family (normative recovery information, encouragement, support, and companionship; enhancement of recovery self-management skills), often delivered in the natural environment of the individual/family
- Community-level recovery education
- Recovery resource identification, mapping, and development, including volunteer recruitment
- Recovery resource mobilization (activating a state of readiness to respond to the needs of an individual/family at a particular point in time)
- Community-level recovery resource development
- Assertive linkage to communities of recovery (support groups and support institutions)
- Assertive linkage to and systems navigation within addiction treatment and allied human services
- Liaison (bridging, brokering/negotiating, partnering) between individual, family, organization, and community
- Recovery-focused skill training aimed at full community participation (education, employment, housing, leisure, worship and pro-recovery family and social relationships)
- Companionship and modeling of recovery lifestyle, including participation in leisure activities that would be judged a breach of ethics for addiction counselors, e.g., eating together at a restaurant, attending or participating in a sporting event, attending a social event such as a concert or recovery celebration event[31]
- Problem-solving to eliminate obstacles to recovery, e.g., linkage to resources for child-care, transportation, community re-entry from jail/prison
- Recovery check-ups (sustained monitoring, support/companionship, and recovery promotion)
- Recovery advocacy for individual/family needs (empower individuals and family members to assert their rights and needs)
- Recovery advocacy for aggregate community needs
- Recovery leadership development
- Conducting a regular self-inventory of personal and organizational performance via reflection, dialogue with service constituents, and analysis of recovery-focused service benchmark data

[31] Wolf and Kerr (1979) recommended such activities under the rubric of "companionship therapy," as a means of lowering post-treatment relapse rates. Wolf, K. & Kerr, D.M. (1979). Companionship therapy in the treatment of drug dependency. In B. S. Brown (ed.), *Addicts and aftercare* (pp. 183-209). Beverly Hills, CA: Sage.

These core functions can be divided into four overlapping stages of recovery support: 1) pre-recovery engagement, 2) recovery initiation and stabilization, 3) recovery maintenance, and 4) enhancement of quality of life in long-term recovery. (One advantage of this staged view of recovery is that it provides a way to transcend the traditional polarization between harm reduction and treatment interventions.) These same functions also encompass different "zones of action and experience" in recovery: physical, psychological (cognitive/emotional), relational, occupational/leisure, and ontological (spirituality/life meaning and purpose).[32]

TREATMENT ADJUNCT OR ALTERNATIVE

As noted, P-BRSS can constitute an adjunct or alternative to professionally directed addiction treatment. The former is often demarcated by:

- pre-treatment P-BRSS (services aimed at identification, relational engagement, motivational enhancement, and treatment entry),
- in-treatment P-BRSS (services aimed at enhancing service quality, continued participation, and treatment completion), and
- post-treatment P-BRSS (services focused on post-treatment recovery checkups, stage-appropriate recovery education, assertive linkage to communities of recovery, early re-intervention, and coaching for enhanced quality of personal/family life in long-term recovery).

Although P-BRSS will never and should never fully replace professionally directed treatment as a means of initiating recovery, P-BRSS can serve as an alternative to treatment for people with low to moderate problem severity and high levels of personal, family, and community recovery capital.[33] P-BRSS may also serve as an alternative for relapsed clients with multiple prior treatment episodes who have mastered the art of initiating recovery through the vehicle of professional treatment but are unable to sustain recovery within their natural environments following discharge from treatment.

Recovery support in the professional literature is very much focused on treatment, but pre-recovery engagement entails far more than the question of how to link someone to treatment, and post-treatment peer support services involve far more than maintaining the improvements made in treatment. P-BRSS involve a larger spectrum of life concerns than those typically addressed in addiction treatment, including basic necessities of living, reconstruction of

---

[32] There are many staged models of recovery that are reviewed by White & Kurtz, 2006, but Rossi's depiction of these as sobriety, happy sobriety, and healthy sobriety is as apt here as any. White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

[33] White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

personal lifestyle, sober fellowship and leisure activities, restitution and community service, and life meaning and purpose. Where treatment focuses on the problems that can be subtracted from the client's life, P-BRSS focus on what can be added during long-term recovery.

In the next chapter, we will explore the history of peer-based addiction recovery support from the mid-1700s to the present.

Chapter Two

History of Peer-Based Recovery Support Services

SUMMARY OF KEY POINTS

- Addiction recovery mutual-aid societies and the specialty sector of addiction treatment emerged in response to the social stigma attached to AOD problems[34] and the history of service exclusion, service extrusion, and ineffective and harmful interventions[35] 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, creating unique cultural and religious pathways of recovery initiation and recovery 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

---

[34] For information on how this stigma influenced attitudes of mainstream service professionals, see: Goodyear, R. (1983). Patterns of counselors' attitudes toward disability groups. *Rehabilitation Counseling Bulletin*, *1*, 181-184. Grob, G. (Ed.) (1981). *Nineteenth-Century medical attitudes toward alcoholic addiction*. NY: Arno Press. Haberman, P.W. & Sheinberg, J. (1969). Public attitudes toward alcoholism as an illness. *American Journal of Public Health, 59*, 1209-1216. Hayman, M. (1956). Current attitudes to alcoholism of psychiatrists in southern California. *American Journal of Psychiatry, 112*, 485-493. Schneider, C. & Anderson, W. (1980). Attitudes toward the stigmatized: Some insights from recent research. *Rehabilitation Counseling Bulletin*, *23*(4), 299-311.

[35] For a recent review of the harm done in the name of help within the history of addiction treatment, see White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals. *Counselor*. 9(6), 10-17.

service ethic within communities of recovery that accompanied the rise of an "alcohol and drug abuse industrial complex."[36]

- 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 politically and culturally and are generating new recovery support institutions that complement 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.

The history of peer-based recovery support in the United States spans the services of solo practitioners, recovery support within larger religious/cultural revitalization movements, formal recovery mutual-aid societies, recovery social clubs, recovery community service institutions, recovering people working in non-professional support roles in addiction treatment and prevention organizations, recovering people working in professional roles in addiction treatment, and recovering people working in allied service organizations. This history has been presented elsewhere in considerable depth.[37] For purposes of this monograph, we will provide a brief summary of peer-based recovery support structures in the United States.

It is important to put this in context. There would be no history of recovery mutual-aid societies, and no history of addiction treatment, if people

---

[36] Hughes, H. (1974, December). *Address before the North American Congress on Alcohol and Drug Problems*. San Francisco, CA.

[37] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2000a). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly, 18*(1), 1-23. White, W. (2000b). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly, 18*(2), *1-25.* White, W. (2000c). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases, 19*(2), 1-10. White, W. (2004a). *The history and future of peer-based addiction recovery support services.* Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Posted at: http://www.facesandvoicesofrecovery.org/pdf/peer-based_recovery.pdf. Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

seeking recovery had found support for recovery within their natural communities and if they had received respect and effective professional help from other health and human service institutions. Historically, recovery mutual-aid movements rise in the absence, under-funding, ineffectiveness, or collapse of professional systems of care.

It is under such circumstances that recovering people turn to one another, discover that they can do together what they are failing to do alone, and conclude that their methods are superior to other methods. The source of any subsequent failure is viewed as rooted within the person rather than in the program.[38] The anti-professionalism that sometimes characterizes recovery mutual-aid movements is rooted in recovering peoples' experience of contempt, service exclusion, service ineffectiveness, and harm done in the name of help within mainstream health and human service institutions.[39]

This collective experience of people with AOD problems set the stage for the rise of addiction recovery support groups and the specialized field of addiction treatment.[40] Historically, traditionally trained helping professionals (physicians, psychiatrists, nurses, psychologists, social workers) enter the field of addiction treatment in large numbers only during periods of increased funding and heightened professional status. When the stigma attached to addiction treatment and recovery rises again, with resulting cutbacks in funding and status, traditional professionals tend to abandon the addictions field for more financially and socially attractive opportunities.

When systems of support and care for addiction recovery collapse, it is recovering people and their families and a small cadre of committed professionals who join together to birth new systems of support and care. In each cycle, such care and support evolve from peer-based to professional-based models, resulting in transition periods of mixed peer/professional characteristics. The therapeutic community, for example, began as a purely peer-based model of recovery and evolved into a professional treatment that retained strong peer elements. The stigma experienced by people in medication-assisted recovery (particularly persons enrolled in methadone maintenance) when they seek involvement in traditional recovery support groups (e.g., Narcotics Anonymous) has led to alternative support groups that mix peer and professional support characteristics.[41] Similarly, SMART Recovery® is usually referred to as a peer

---

[38] Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher. Toch, H. (1965). *The social psychology of social movements*. Indianapolis: Bobbs-Merrill.

[39] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[40] For a discussion of the aversion to alcoholics/addicts among mainstream service professionals, see: Googins, B. (1984). The avoidance of the alcoholic client. *Social Work*, *29*, 161-166. White, W. (2003b). A history of contempt: Countertransference and the dangers of service integration. *Counselor, 4*(6), 20-23.

[41] Nurco, D.N., Stephenson, P., & Hanlon, T.E. (1991). Contemporary issues in drug abuse treatment linkage with self-help groups. In R. W. Pickens, C. G. Leukefeld, & C. D. Schuster (Eds.), *Improving drug abuse treatment* (NIDA Research Monograph, 106; pp. 338-348). Rockville, MD: National Institute on Drug Abuse.

recovery support program but continues to use professional facilitators for many of its meetings.

The following discussions outline the history of peer-based models of recovery support.

Solo Practitioners

People recovering from alcohol and other drug addictions have a long history of reaching out to others similarly afflicted. Solo practitioners pursue this outreach in relative isolation from other organized frameworks of recovery support. Most often, they do so to bolster their own recovery and to fulfill a newfound calling to help others. In the nineteenth century, such persons traveled from town to town giving temperance lectures, providing personal consultations to inebriates and their families, organizing local recovery support meetings, and maintaining a prolific correspondence with those seeking recovery.

This style of recovery evangelism is well illustrated in the biographies of nineteenth-century temperance missionaries John Hawkins,[42] John Gough,[43] Edward Uniac,[44] George Dutcher,[45] Luther Benson,[46] and Thomas Doutney.[47] These accounts attest to the special kinship that existed between the "reformed reformers" and those still suffering addiction to strong drink.[48]

> *I can sympathize with and appreciate the condition of the poor inebriate. Have I not been one of their number? I now have an object in life—to reform men.*[49]

> *They* [reformed men] *understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard's heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform...* (from the *Mercantile Journal*, May 27, 1841.[50])

---

[42] Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.
[43] Gough, J. (1870). *Autobiography and personal recollections of John B. Gough.* Springfield, MA: Bill, Nichols & Company.
[44] Berry, J. (1871). *UNIAC: His life, struggle, and fall*. Boston, MA: Alfred Mudge & Son.
[45] Dutcher, G. (1872). *Disenthralled: A story of my life.* Hartford, Connecticut: Columbian Book Company.
[46] Benson, L. (1896). *Fifteen years in hell: An autobiography*. Indianapolis: Douglas & Carlon.
[47] Doutney, T. (1903). *Thomas Doutney: His life, struggle and triumph*. Battle Creek, MI: The Gage Printing Company, Limited.
[48] A Member of the Society. (1842). *The foundation, progress and principles of the Washingtonian Temperance Society of Baltimore, and the influence it has had on the temperance movements in the United States*. Baltimore: John D. Toy.
[49] Doutney, T. (1903). *Thomas Doutney : His life, struggle and triumph*. Battle Creek, MI: The Gage Printing Company, Limited.
[50] Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.

The relapse rate was high for those not linked to a recovery mutual-aid society. Luther Benson, like many solo practitioners, relapsed repeatedly during his career as a temperance missionary. With each relapse, he threw himself more intensely into the work in the hope it would take the place of alcohol. Following his admission to the Indiana Asylum for the Insane in 1896, Benson reflected on this failed strategy.

> *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*.[51]

People who experience recovery outside professional treatment or mutual-aid groups have continued this recovery missionary tradition as solo practitioners. There are fewer such solo practitioners today due to the number of competing recovery support structures, but if such structures should ever collapse, solo recovery advocates would quickly rise to fill this void.

Peer Recovery Support and Religious/Cultural Revitalization Movements

Abstinence-based religious and cultural revitalization movements have provided a source of shelter and support for people seeking addiction recovery. When alcohol problems first rose within American Indian communities, a series of indigenous movements offered cultural pathways of recovery for individuals, families, and tribes. The earliest of these movements included the Handsome Lake Movement (1799), the Indian Prophet Movements (1805-1830s), the Indian Shaker Church (1882), and the Native American Church (1918), and this tradition continued in the contemporary period through the "Indianization of Alcoholics Anonymous," the Red Road, and the Native American Wellbriety movement.[52]

Outside Native America, people seeking recovery found peer-based support within the American Temperance movement's network of temperance societies, temperance meetings, temperance hotels, and temperance libraries,[53] as well as within the larger religious awakening occurring in the United States in the eighteenth and early nineteenth centuries. The recovery-focused ministries within these larger religious movements were led by people in recovery. Recovery-focused ministries span the urban mission movement and religious

---

[51] Benson, L. (1896). *Fifteen years in hell: An autobiography*. Indianapolis: Douglas & Carlon.

[52] Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc. Womak, M.L. (1996). *The Indianization of Alcoholics Anonymous: An examination of Native American recovery movements.* Master's thesis, Department of American Indian Studies, University of Arizona.

[53] Sigorney, L. & Smith, G. (1833). *The intemperate and the reformed*. Boston: Seth Bliss.

inebriate colonies of the late nineteenth century to the current growth of recovery ministries and recovery churches.[54]

Recovery support initiatives were also spawned within the larger mid-twentieth-century civil rights; women's liberation; and lesbian, gay, bisexual, and transgender (LGBT) rights movements. The recovery ministry of the Reverend Cecil Williams and Glide Memorial Church in the Tenderloin District of San Francisco was a natural outgrowth of the civil rights movement and set a model for recovery ministries within disempowered communities.[55] Women for Sobriety, founded by Dr. Jean Kirkpatrick in 1975, was a product of the consciousness raising within the women's movement.[56] At the height of the youth counterculture movement of the 1960s, young people recovering from dependence on drugs other than alcohol and heroin felt little identification with the recovery cultures of AA or NA. They found service roles within indigenous service organizations, e.g., the Diggers (the service institution within the San Francisco youth counterculture), folk medicine institutions ("acid rescue"), crisis lines, "crash pads," and youth-focused counseling centers. Similarly, recovering people within the LGBT movement played key service roles within indigenous responses to the AIDS epidemic and championed LGBT recovery support meetings and LGBT-sensitive addiction treatment.

Abstinence-based religious and cultural revitalization movements have been strongest in historically disempowered communities of color in which alcohol and other drugs are deeply entwined with histories of enslavement and colonization.[57] Hope for personal recovery from addiction for members of a culturally besieged group is best couched in a larger framework of hope for a community and a people.[58]

Secular Recovery Mutual-aid societies

Secular recovery frameworks are distinctive in that they extol the power of personal (rational) will and mutual fellowship rather than God as the source of strength in overcoming alcohol and other drug problems. Prominent secular

---

[54] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51. Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco. Sanders, M. (2002). The response of African American communities to alcohol and other drug problems. *Alcoholism Treatment Quarterly*, *20*(3/4), 167-174.

[55] Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco.

[56] Kirkpatrick, J. (1978). *Turnabout: Help for a new life*. Garden City, NY: Doubleday and Company. Kirkpatrick, J. (1986). *Goodbye hangovers, Hello life.* NY: Ballantine Books.

[57] Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

[58] 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.

recovery support societies in the United States have included the Washingtonians (1840), multiple fraternal temperance societies (1840s to 1890s), the Dashaway Association (1859), the Ribbon Reform Clubs (1870s), the Business Men's Moderation Society (1879), Women for Sobriety (1975), Secular Organization for Sobriety (1985), Rational Recovery (1986), Men for Sobriety (1988), SMART Recovery® (1994), Moderation Management (1994), and LifeRing Secular Recovery (1999).[59] Secular recovery groups have grown in number since 1975, but the availability of face-to-face meetings continues to be geographically limited. This limitation is balanced by the rapid growth in Internet-based secular recovery support meetings.

Spiritual Recovery Mutual-aid societies

Alcoholics Anonymous (AA) (1935) pioneered a spiritual, 12-Step program of recovery that has been widely adapted for other problems. Addiction recovery societies that have adapted AA's program include Narcotics Anonymous (1953), Pot Anonymous (1968), Pills Anonymous (1975), Chemical Dependent Anonymous (1980), Recoveries Anonymous (1981), Cocaine Anonymous (1982), Nicotine Anonymous (1985), Marijuana Anonymous (1989), Benzodiazepines Anonymous (1989), Crystal Meth Anonymous (1994), Prescription Drugs Anonymous (1998), and Heroin Anonymous (2004). Twelve-Step groups also exist for medication-assisted recovery (Methadone Anonymous, 1991; Advocates for the Integration of Recovery and Methadone, 1991; Mothers on Methadone, 2005). Twelve-Step groups are the most geographically dispersed and available recovery support meetings in the United States.

Religious Recovery Mutual-aid societies

Some recovery mutual-aid societies use deep religious experiences, religious ideas and rituals, and enmeshment in a faith community to initiate and sustain recovery and enhance the quality of personal/family life in recovery. Societies formed particularly for this purpose include the United Order of Ex-Boozers (1912); the Calix Society (1947); Alcoholics Victorious (1948); Alcoholics for Christ (1976); Overcomers Outreach (1985); Jewish Alcoholics, Chemically Dependent People and Significant Others (1979); Liontamers Anonymous (1980); Free N'One (1985); Celebrate Recovery (1990); Millati Islami (1989); and Victorious Ladies (ND). Celebrate Recovery is currently the fastest growing faith-based recovery support group in the United States, with groups in more than 10,000 churches.

[59] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2004). Addiction recovery mutual-aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538.

Family-focused Recovery Support Societies

Some recovery support societies support family members affected by alcohol and drug addiction. The most prominent of these societies have included the Martha Washington Society (1842), Alcoholics Anonymous Associates and AA Auxiliaries (1946-1950), Al-Anon (1951), Alateen (1957), Nar-Anon (1968), Families Anonymous (1971), Adult Children of Alcoholics (1978), Because I Love You (1982), National Association for Children of Alcoholics (1983), Co-Anon (1983), Codependents Anonymous (1986), and Recovering Couples Anonymous (1988). The most accessible family recovery support group in the U.S. is Al-Anon, with 14,924 groups in the U.S. and Canada.[60]

Occupation-based Recovery Support Groups

Recovery support societies (mostly 12-Step-associated groups) have formed for particular professional groups in recovery, including physicians (1949), lawyers (1975), women in religious orders (1979), psychologists (1980), social workers (1981), pharmacists (1983/1984), anesthetists (1984), nurses (1988), ministers (1988), and veterinarians (1990). These groups provide a very special form of peer support for people who face special challenges in recovery (e.g., ready access to drugs) and whose professional practice could be harmed by the stigma attached to addiction. They often operate in close association with formal professional assistance programs.

Shared Characteristics of Recovery Support Groups

Much has been made of the differences between recovery support groups, but less attention has focused on what these groups share in common that distinguishes them from professionally directed addiction treatment. Such collective distinguishing characteristics include:

- origin and structure (spontaneous, self-governed movements);
- recovery context (recovery support is provided while living in one's own natural environment; there is no re-entry or concern about transfer of learning from institutional to natural settings);
- organizational context (mutual support provided through the medium of a community rather than through a professional/business organization);
- lack of hierarchy (purpose is to help one another with common problems—no one has claim to a morally superior position; no dichotomy between helper and helpee roles);
- support relationships guided by "group conscience" rather than codes of professional ethics or legal regulations;
- welcoming (emphasis on warm social fellowship);

[60] Al-Anon (2006). *Membership Survey Results, Al-Anon Family Groups, Fall 2006*. Retrieved August 30, 2006 from http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf.

- motivational enhancement via mutual encouragement and celebration of sobriety birthdays;
- practical antidotes to guilt (self-inventory, confession, acts of restitution, acts of service);
- pragmatism (focus on well tested strategies of daily living rather than theories about or extensive analysis of problem development);
- no intake, no diagnosis, no medical record;
- a strong service ethic through which members reach out to those still suffering from addiction;
- sustained availability of support during times of heightened vulnerability (e.g., evenings, nights, and weekends) when professionals are generally not available;
- support not contingent upon personal financial resources or the vagaries of public funding; and
- guidance provided via experience-based suggestions rather than rules or prescriptions.

Recovery Support for Special Populations

When individuals struggle to meet their needs within mainstream recovery support groups or when aspects of their experience are difficult to address within mainstream groups, recovering people have sought out others like themselves to share their "experience, strength, and hope" on these issues.

***Gender-specific mutual-aid groups*:** Recovery support groups for women began within the Martha Washington societies of the 1840s, but, like most groups that would follow, these societies tried to integrate recovering women into support groups for wives and mothers of alcoholics. The first sustainable recovery support groups designed specifically for addicted women were started in the early 1940s within Alcoholics Anonymous. Female pioneers within AA began meeting together to share experiences and support on issues they could not raise in mixed-gender meetings. Twelve-Step meetings for women are now common in communities across the United States.

The second half of the twentieth century witnessed the development of alternatives to 12-Step groups for women, including Women for Sobriety, founded by Dr. Jean Kirkpatrick; Charlotte Kasl's Sixteen Step Groups; and such faith-based recovery support groups as Women on the Move and Ladies Victorious.[61] Men-only meetings also have risen within AA/NA, and Men for Sobriety was founded as an alternative recovery support group for men in 1988.

Beyond recovery support groups, gender-specific recovery support services grew out of efforts to craft an approach to addiction treatment based

[61] Kasl, C. (1992). *Many roads, one journey*. New York: Harper Perennial. Kirkpatrick, J. (1978). *Turnabout: Help for a new life*. Garden City, NY: Doubleday and Company. Kirkpatrick, J. (1981). *A fresh start*. Dubuque: Kendall/Hunt Publishing. Kirkpatrick, J. (1986). *Goodbye hangovers, Hello life.* NY: Ballantine Books. Williams, C. with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities.* NY: Harper San Francisco.

specifically on the needs of addicted women. Peer-based outreach services, mentoring programs, parenting education and coaching, trauma support groups, child care co-ops, and linkage to educational opportunities were included in these efforts.[62] There have also been recent efforts to blend a recovery home for women and a women's community recovery center within the same program.[63]

***Age-specific recovery support*:** Special support for young people seeking recovery began in the mid-nineteenth century cadet branches of the Washingtonians, the Ribbon Reform Clubs, and the Keeley Leagues.[64] Young people's groups in AA began in the 1940s and led to the founding in 1958 of the International Conference of Young People in Alcoholics Anonymous—an annual event that now draws more than 3,000 young AA members from all over the United States. Alateen, which was founded in 1957, also serves as a source of support for adolescents who struggle with the alcoholism of a parent, as well as a pathway of entry into recovery for some of these young people who develop AOD problems.

Other peer recovery support frameworks that have meetings for youth—although with far fewer meetings than found in AA—include Narcotics Anonymous, Alcoholics Victorious, and Teen-Anon.[65] There is also a tradition of "old-timers" recovery support meetings in many communities. These meetings provide a forum to address later-stage recovery tasks and to address age-related issues that can pose a special challenge to late-stage recovery (e.g., loss of spouse, retirement, age-related health problems, physical disability, chronic pain, terminal illness).

***Recovery mutual aid and advocacy in communities of color*:** As noted earlier, historical research has placed the beginnings of peer-based recovery support within mid-eighteenth century Native American tribes. Peer recovery support was provided within larger, abstinence-based cultural and religious revitalization movements and was followed by the cultural adaptation of culturally dominant support structures, e.g., the "Indianization of AA," or the use of mainstream religious institutions for support for sobriety.[66] According to the

---

[62] 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.

[63] Haberle, B. & White, W. (2007). *Gender-specific recovery support services: The evolution of the Women's Community Recovery Center*. Posted at http://www.facesandvoicesofrecovery.org/pdf/White/white_haberle_2007.pdf.

[64] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[65] Passetti, L. & White, W. (2008). Recovery meetings for youths. *Journal of Groups in Addiction and Recovery, 2*, 97-121. Published simultaneously as: Passetti, L.L. & White, W.L. (2008). Recovery support meetings for youths: Considerations when referring young people to 12-Step and alternative groups. In J.D. Roth & A.J. Finch (Eds.), *Approaches to substance abuse and addiction in education communities: A guide to practices that support recovery in adolescents and young adults*. NY: Haworth Press.

[66] Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie*. Colorado Springs, CO: White Bison, Inc. Womak, M.L. (1996). *The Indianization of Alcoholics Anonymous: An examination of*

research of Crowley,[67] Frederick Douglass was the most prominent of early African Americans in recovery. Douglass spoke openly of a period of intemperance in his life, signed a pledge of abstinence in 1845, maintained sobriety the rest of his life, and worked to promote Black temperance groups. Through his encouragement and example, nineteenth-century African Americans generated their own temperance and mutual-aid societies, e.g., the Black Templars. These societies and their pledges framed sobriety within the historical and cultural context of the post-Civil War years:

> *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* (Temperance Tract for Freedman).[68]

People of color entered AA in the 1940s, and the first African-American AA group was established in Washington, DC in 1945. This was quickly followed by African American groups in St Louis, Valdosta (GA), and Harlem.[69] The history of recovery within Hispanic and Asian communities has yet to be documented. We will later review the scientific evidence related to the degree of participation of people of color in mainstream recovery support groups and report the affiliation rates and recovery outcomes of people of color within these groups.

***Recovery support for and within the LGBT community*:** The first addiction recovery support group organized specifically for members of the lesbian, gay, bisexual, and transgender (LGBT) community was an AA meeting founded for gay men in Boston in 1949. Early LGBT AA meetings existed without being formally identified in AA meeting lists. The number of cities with gay AA groups grew from seven in 1975 to more than 300 in 1990.[70] Today, in cities like Chicago, there are more than 50 LGBT-focused AA meetings per week.

***Recovery support for people with co-occurring disorders*:** People concurrently recovering from substance use and psychiatric disorders often find themselves marginalized from mental health support groups and mainstream addiction recovery support groups. Such marginalization led to the emergence of three specialty support groups: Dual Disorders Anonymous (1982), Dual Recovery Anonymous (1989), and Double Trouble in Recovery (1993). (See later discussion of research on these groups in Chapter Four.)

Native American recovery movements. Master's thesis, Department of American Indian Studies, University of Arizona.

[67] Crowley, J. (1997). Slaves to the bottle: Gough's autobiography and Douglass's narrative. In D. Reynolds & D. Rosenthal (Eds.), *The serpent in the cup: Temperance in American literature*. Amerherst, MA: University of MA Press.

[68] Cheagle, R. (1969). *The colored temperance movement* (Unpublished thesis). Washington, DC: Howard University.

[69] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[70] Borden, A. (2007). *The history of gay people in Alcoholics Anonymous from the beginning*. New York: Haworth Press.

***Recovery support for people embedded within the criminal justice system*:** Recovery support groups have existed independent of, grown out of, or spawned inmate recovery counseling programs, e.g., the Addiction Recovery Counseling program at San Quentin Prison.[71] Most of these programs were the fruit of volunteers from community-based recovery support groups (particularly AA and NA) carrying recovery messages to local jails and prisons. Winner's Circle, a recovery support program for ex-offenders, started in Connecticut in 1988 and was rebirthed and revamped in Texas in 1998. It has developed into a broader Winner's Community concept that involves Inner Circle (institution-based) and Winner's Circle (community-based) recovery support meetings to address the special obstacles offenders face in community re-integration and long-term recovery.[72]

***Recovery mutual aid in rural communities*:** People seeking recovery support in rural communities face many obstacles: 1) the absence or scarcity of mainstream recovery support meetings, 2) the absence of specialty meetings like those just described, and 3) problems meeting accessibility for those without driving privileges. These obstacles are being addressed, in part, through carpooling to access regional recovery support meetings, P-BRSS delivered face to face in people's homes, and P-BRSS services delivered via telephone (voice and text) and Internet.

Summary: Seen as a whole, specialty recovery support groups provide a:

- sanctuary of mutual identification and support for individuals estranged from mainstream community life,
- means of making sense of the recovery process through key developmental transitions,
- place of safety and shelter for high-status individuals in recovery whose careers or social standing could be injured by public disclosure of their addiction/recovery status,
- venue through which stigmatized populations can address their shared experience and unique obstacles to recovery, and
- forum to address recovery from addiction and co-occurring medical or psychiatric conditions.

If there is a contemporary story of recovery mutual aid, it is that of the growing varieties of recovery pathways and recovery experiences—all of which are cause for celebration. A regularly updated directory of this growing network of addiction recovery mutual-aid groups can be found at www.facesandvoicesofrecovery.org.

---

[71] De Miranda, J. (2006). Recovery inside San Quentin Prison, training inmate counselors. *Alcoholism & Drug Abuse Weekly*, *18*(39), 5-5.

[72] The first national strategic planning meeting to expand the Winner's Community nationally was held in Hartford, CT in July 2008. Personal communication with Steven Shapiro.

GEOGRAPHICAL ACCESSIBILITY OF RECOVERY MUTUAL-AID GROUPS

Identification of the growing variety of recovery support groups leaves open the question of whether these options are really available to people in most communities in the United States. Table 4 illustrates the geographical availability of these groups. The founding date of each group is included so that the reader can estimate the rate of yearly growth of each recovery fellowship.

Table 4: Geographical Dispersion of Addiction Recovery Mutual-aid Groups in the United States[73]

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Addictions Victorious	1986	45 meetings in 5 states (MD, NJ, NY, PA, and WA)
Addicts Victorious	1987	21 meetings in 5 states (IL-8, IO-1, MO-10, & TX-3)
Adult Children of Alcoholics	1978	1,500+ meetings
Al-Anon/Alateen	1951/1957	14,924 groups in the U.S. and Canada; all 50 states [74]
Alcoholics Anonymous	1935	More than 52,500 groups; all 50 states
Alcoholics for Christ		113 groups in U.S.; a particularly heavy concentration (43) in Detroit.
Alcoholics Victorious	1948	164 groups in U.S.
All Recoveries Anonymous	1981	50 chapters
Anesthetists in Recovery	1984	150+ members; provides phone support and linkage to support meetings
Benzodiazepines Anonymous	1989	Currently inactive
Benzo	1999	Online recovery support group for those withdrawing from benzodiazepines **http://www.benzosupport.org/**
Calix Society (adjunct to AA)	1947	27 affiliates in 18 states
Celebrate Recovery	1991	Faith-based peer recovery program in 10,000 churches across all 50 states
Chemically Dependent Anonymous	1980	65 groups

[73] Groups listed in this table were defined as currently inactive if multiple efforts to reach the group by listed phone and email failed to generate a direct response or information.

[74] Al-Anon (2006). *Membership Survey Results, Al-Anon Family Groups, Fall 2006*. Retrieved August 30, 2006 from http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf.

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Christians in Recovery	1992	All meetings held online
Cocaine Anonymous	1982	2,500 groups; most states
Co-Anon	1985	28 international groups
Co-Dependents Anonymous	1986	1,100 meetings worldwide
Crystal Meth Anonymous	1995	Meetings in all states
Double Trouble in Recovery	1989	250 groups
Dual Diagnosis Anonymous	1998	56 groups; 38 in CA
Dual Disorder Anonymous	1982	48 groups; most in Illinois
Dual Recovery Anonymous	1989	345 groups; 4 states (CA, OH, PA, MA)
Families Anonymous	1971	220 groups in 36 states
Free N'One	1985	55 groups
Heroin Anonymous	2004	35 meetings in Arizona, California, Illinois, Michigan, Texas, Utah, Washington
Intercongregational Addictions Program	1979	Support for recovering women in religious orders through phone, email, and conferences; membership of 710 plus in IL, Mass., Michigan, Alabama, California, New York, New Jersey, and Wisconsin
International Doctors in Alcoholics Anonymous	1949	175 groups; 6,000+ members
International Lawyers in Alcoholics Anonymous	1975	40+ groups; support through newsletter, conventions, and local meetings
International Ministers and Pastors in Recovery	1988	Support through phone network and international conference
International Nurses Anonymous	1988	Support through phone network, regional meetings, and international conference; INA provides those seeking help with names of recovering nurses in their area, who then do the linkage to support meetings
International Pharmacists Anonymous	1983/1984	Meetings held in tandem with summer schools and addiction conferences; annual regional meetings

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS)	1980	50 groups in 19 states; networking, community outreach, retreats, newsletter, literature, speakers bureau
LifeRing Secular Recovery	1999	73 groups in 15 states; 48 meetings in CA
Liontamers Anonymous	1980	No currently active meetings
Marijuana Anonymous	1989	200 groups; 24 states
Men for Sobriety	1988	5 affiliated groups, meetings primarily in Canadian Provinces
Methadone Anonymous	1991	400+ groups; 25 states
Millati Islami	1989	50 groups (12-Step adaptation based on Islamic principles drawn from the *Qu'ran* and *Hadith*, the sayings and practices of the Prophet Mohammad)
Moderation Management	1994	16 meetings; 12 states
Mothers on Methadone	2005	Online support available at http://www.methadoneanonymous.us/
Nar-Anon	1967	1,600 groups; 47 states; also sponsor Nar-Ateen and Nar-Atot meetings
Narcotics Anonymous	1953	More than 15,000 groups; 43,900 weekly meetings; 127 countries and all 50 states
Nicotine Anonymous	1985	450 groups; most states
Nurses in Recovery		Provide online message board for nurses in recovery
Overcomers in Christ	1987	100 churches, missions, and jail ministries registered
Overcomers Outreach	1985	700+ meetings in North America
Pagans in Recovery		All groups online
Pills Anonymous	1975	2 groups in New York City; also have San Francisco-based web support
Pot Anonymous	1968	Currently inactive; see Marijuana Anonymous
Prescription Drugs Anonymous	1998	Online support available at http://dailystrength.org/c/Prescription-Drug-Abuse/support-group

Mutual Aid Group	Founding Date	Number and Distribution of Groups and Meetings in U.S. in 2007-2008
Psychologists Helping Psychologists	1980	Support through newsletter and regional/national meetings
Rational Recovery	1986	There have been no RR group meetings since 1994; earlier groups now meet under auspices of SMART Recovery®.
Recoveries Anonymous	1981	50 Chapters
Recovering Couples Anonymous	1988	125 active meetings
Secular Organization for Sobriety	1986	480 groups; all 50 states
SMART Recovery®	1994	353 groups; 40 states
Social Workers Helping Social Workers	1981	Support through newsletter, email, and regional meetings; 300+ members
Teen-Anon	1999	Presently inactive
Veterinarians in Recovery	1990	Newsletter and online email support
Winner's Community	1988/1993	Local Winner's Circle groups now organizing into national Winner's Community network of recovering ex-offenders; local chapters with support meetings available in five states (IL, OH, IO, TX, KS)
Women for Sobriety	1975	200 groups in U.S.

Sources: Kelly & Yeterian (2008)[75] and direct group contact, with assistance from Jim Russell, Oklahoma Faces and Voices of Recovery; Groups are listed as currently inactive if web sites would not open or repeated calls to listed numbers went unanswered. Regularly updated information on these groups can be obtained from www.facesandvoicesofrecovery.org.

It can be seen from Table 4 that the accessibility of specific recovery support groups varies widely from state to state and community to community. P-BRSS specialists can play important roles in stimulating the development of recovery support alternatives in their local communities and in encouraging the use of online recovery support for people who do not have access to or are not comfortable in mainstream meetings.[76]

[75] Kelly J. F. & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J. R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

[76] For a discussion of strategies to nurture the development of local recovery support groups, see: White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

Program Profile 1: Peer Group Facilitation Training (previously called "How to Start Your Own Self-help Group")[77]
Purpose: To enhance the abilities of peers in recovery to organize and facilitate recovery support groups and other recovery-related meetings (Started in 2007)
Service Elements: Two-day training design that includes 1) overview of Philadelphia behavioral health systems-transformation process, 2) methods of recovery support group development, 3) tips for meeting facilitation, 4) how to handle difficult situations.
Service Volume/Status: Since its inception, six trainings have been held, with more than 65 persons completing the training; a follow-up evaluation of the number of groups started by trainees as a result of the training is planned for 2009-2010.
Service Lessons: 1) An excellent gateway to other training and opportunities; 2) unanticipated benefit from personal network development via exchange of contact info between trainees; 3) Development of a learning community among training participants who have expertise in various aspects of group development and facilitation.
For More Information: Contact Seble Menkir at seble.menkir@phila.gov or 215-685-5498 or Ellen Faynberg at Ellen.Faynberg@phila.gov or 215-685-5463

INTERNET-BASED RECOVERY SUPPORT

Members of Alcoholics Anonymous began seeking out other AA members through USENET as early as 1983. Online AA communications increased throughout the 1980s and 1990s and now constitute a significant zone of growth in AA participation. Online recovery support groups sponsored by organizations other than AA began in the mid-1990s and have also grown exponentially. The Internet will be an increasingly important platform for recovery support in the future, and a day may arrive in the not-so-distant future when more people participate in online recovery support than in face-to-face meetings.

RECOVERY COMMUNITY SERVICE INSTITUTIONS AND ORGANIZATIONS

Communities of recovery have a long history of birthing service institutions to help people who needed more than could be provided within the framework of recovery support meetings. These service institutions date back to the founding of the first inebriate home in Boston (1857) and span a long line of support structures, including the rise of "AA homes and retreats," information and referral centers, halfway houses, and early detoxification and treatment centers.

The recent growth of recovery community organizations (RCOs) marks a new development within the long history of recovery support. They are neither recovery mutual-aid societies nor professional treatment institutions. These new

[77] Personal communication with Ellen Faynberg, November, 2008.

organizations reflect the political and cultural awakening of recovering people and their families.[78]

RCOs support a wide variety of new recovery support institutions: recovery community centers, recovery homes, recovery colonies, recovery schools, recovery industries, recovery ministries/churches, recovery cafes, recovery-based sports teams, recovery book clubs, recovery-themed radio and television programming, and recovery-themed art (from recovery music to recovery murals). Several of these emerging institutions are profiled in Chapter Five. These recovery community-building activities constitute one of the forces pushing addiction treatment programs to become "recovery-oriented systems of care" and to wrap traditional clinical services within a larger and more time-extended umbrella of P-BRSS.

Program Profile 2: PRO-ACT Philadelphia (Philadelphia, PA)[79]
Purpose: "engage, activate, educate, and support" individuals and families in recovery; provide resources that help individuals/families initiate/sustain recovery and enhance their quality of life in long-term service.
Service Elements: 1) community education, 2) policy advocacy, 3) recovery support services, 4) recovery celebration/recreation, and 5) community service
Service Volume/Status: In all, 19,525 people were served in PRO-ACT activities this year.
Service Lessons: Importance of 1) broad representation across religious, spiritual and secular communities of recovery; 2) sustaining participatory processes; 3) sustaining focus on recovery community-building; 4) managing initial resistance through respect for critics, persistence, enduring service, and leading by example; 5) developing a collaborative relationship with professional treatment agencies and allied service agencies.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

RECOVERY SOCIAL CLUBS

One of the most distinctive recovery community institutions is the recovery clubhouse. Recovery social clubs provide a haven of recovery fellowship and an outlet for sobriety-based leisure activities. The most notable of these clubs (many started by patients during their stay at treatment programs) have included the Ollapod Club (1868), the Drunkard's Club (1871), the Godwin Association (1872), the Bi-Chloride of Gold Clubs (Keeley Leagues, 1891), the Jacoby Club (1910), and AA and other 12-Step Clubhouses (1940s-present). Until recently, recovery social clubs were restricted to 12-Step clubhouses; since

[78] Valentine, P., White, W., & Taylor, P. (2007). *The recovery community organization: Toward a definition*. Retrieved from http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf.

[79] Personal communication with Bev Haberle, December, 2008.

early 2000, Recovery Community Centers that combine social club and recovery support service functions for people who embrace diverse recovery pathways are growing rapidly.

RECOVERY ADVOCACY ORGANIZATIONS

Individuals and family members in recovery have a rich modern history of founding recovery advocacy organizations. Particularly noteworthy is the work of the National Committee for Education on Alcoholism (1944)—the precursor to today's National Council on Alcoholism and Drug Dependence (NCADD), founded by Mrs. Marty Mann, "the first lady of Alcoholics Anonymous." Recovering people played key leadership roles through NCADD that contributed to the rise of mid-twentieth century addiction treatment. They also played key roles in creating new treatment modalities that would be replicated widely across the United States, e.g., the Minnesota Model of alcoholism treatment (1948-1950) and the birth of ex-addict-directed therapeutic communities (1958).

Recovery advocacy organizations have included the Addicts' Rights Organization (1970, Philadelphia); the Committee of Concerned Methadone Patients and Friends, Inc. (1973, New York City); Association of Former Drug Abusers for Prevention and Treatment (ADAPT, New York, 1979); the Society of Americans for Recovery (SOAR), founded by former Senator Harold Hughes (1990); Advocates for the Integration of Recovery and Methadone (1991); National Alliance of Methadone Advocates (1988); local chapters of the National Council on Alcoholism and Drug Dependence that sought to recapture their public education and policy advocacy missions (late 1990s); and new grassroots recovery advocacy organizations (many of which received seed money from the Center for Substance Abuse Treatment's Recovery Community Support Program, RCSP, 1998).[80]

The Alliance Project grew out of the Johnson Institute's Leadership Forum and set the stage for the 2001 Recovery Summit in St. Paul, Minnesota. At the Summit, Faces & Voices of Recovery was founded as a national infrastructure to launch a national educational and advocacy campaign. A directory of local recovery advocacy organizations can be found at www.facesandvoicesofrecovery.org. In 2003, the Center for Substance Abuse Treatment shifted the focus of its RCSP from recovery advocacy to peer-based recovery support services. (See later discussion.)

---

[80] Woods, J.S. (1992). Advocacy and making change: The voice of the consumer. In: J.H. Lowinson, P. Ruiz, R.B. Millman, and J.G. Langrod (Eds.), Substance Abuse: A Comprehensive Textbook (2nd Edition). Baltimore, MD: Williams and Wilkens, pp. 865-873; While other countries have witnessed some political organizations of active drug users (e.g., the founding of the Swedish Users Union in 2002, see Palm, 2006), no such group has formed in the United States whose primary interest is advocacy on behalf of harm reduction, treatment, or recovery-related issues. Palm, J. (2006). The consumer, the weak, the sick, the innocent: Constructions of "the user" by the Swedish Users Union. In J. Anker, V. Asmussen, & D. Tops, (Eds.), *Drug users and spaces for legitimate action* (NAD Monograph no. 49, pp. 159-182). Helsinki, Finland: Nordic Alcohol and Drug Council.

Program Profile 3: Recovery Walk 2008 (Philadelphia, PA)[81]
Purpose: To conduct a highly visible recovery celebration event that honors individuals and families in recovery and provides recovery-focused education to the wider community; to build and mobilize "constituency of consequence" to advocate pro-recovery social policies and programs.
Service Elements: 1) Recovery program speakers and march through Fairmount Park, 2) advocacy tent with voter registration, 3) recovery education tent, 4) honoring of more than 100 recovery leaders with more than ten years of sobriety, 4) exhibits by treatment and recovery support organizations, 5) clothing handout, 6) barbeque and music following program and march.
Service Volume/Status: 4,500+ participants, including representatives from federal, state, and city government.
Outcomes: 1) Offering "living proof" of larger recovery community constituency exerts significant influence on participants, political leaders, and the larger community; 2) recovery celebration events are enormously validating and a vehicle for expunging internalized stigma/shame related to addiction. The event also allowed for increased networking among providers and a springboard to collaboration on additional advocacy efforts.
Lessons Learned: 1) Meticulous planning is the key to success of such major public events, 2) recovery celebration paraphernalia (e.g., t-shirts, hats, etc.) are important devices for recovery community building across pathways of recovery.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

Recovering People Working in Non-professional Support Roles in Addiction Treatment

People in recovery worked as managers and aids in early inebriate homes, and in a variety of roles in urban missions and religion-oriented inebriate colonies in the mid-nineteenth century. Whether or not they should be included in medically oriented inebriate asylums and private addiction cure institutes was a subject of considerable debate and controversy. In spite of such controversies, recovering people continued to serve in non-professional roles in addiction treatment. Sobered alcoholics (and later ex-addict paraprofessionals) worked as attendants, techs, and aides in state psychiatric hospitals through the early-mid twentieth century and then made up nearly the entire workforce within the alcoholism halfway house movement of the 1950s and 1960s.[82]

[81] Personal communication with Bev Haberle, December 2008.

[82] Blacker, E. & Kantor, D. (1960). Half-way houses for problem drinkers. *Federal Probation, 24*(2), 18-23. Rubington, E. (1967). The halfway house for the alcoholic. *Mental Hygiene, 51*, 552-560.

Recovering people then staffed a growing network of detox programs, residential treatment programs, and "social model" programs as volunteers, nursing aides, patient advocates, urinalysis monitors, clerical assistants, house managers, peer helpers, cooks, maintenance staff, drivers, outreach workers, and community educators.[83] Recovering men such as David M., Warren T., and Earl S. pioneered programs in business and industry to counsel alcoholic employees—precursors to the employee assistance counselor and modern peer assistance programs for physicians, nurses, and other professionals.[84]

There is a rich history of recovering people serving as volunteers in addiction treatment to support people in recovery. This volunteer service work was often an extension of the service ethic within recovery mutual-aid programs and was delivered either within the framework of such programs (for example, Twelfth-Step calls, sponsorship, and other service work in AA) or through the framework of a volunteer program sponsored by an addiction treatment organization. AA volunteer work in hospitals began in the 1930s[85] and has continued to the present.

In 1970, the Lutheran General Hospital alcoholism treatment unit in suburban Chicago used more than 125 AA volunteers a month, including pairs of volunteers who were scheduled for all-night duty. Within a 30-day stay, patients were exposed to more than 60 recovering people from all walks of life.[86] A similar program utilizing more than 60 AA volunteers flourished in Cleveland's Cuyahoga County Hospitals.[87] These volunteer programs were extolled for their positive effects on people undergoing treatment, and they often constituted the preparatory and recruiting grounds for addiction counselors.[88] As drug problems rose in communities during the 1960s and early 1970s, young recovering addicts

---

[83] Borkman, T. J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, *15*(1), 7-17. Flores, V.J. & Rice, K.A. (1974). Training viewpoints on paraprofessional counselors. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1048-1050). Cambridge, MA: Schenkman. Talbott, J.A., Ross, A. M., Skerrett, A. F., Curry, M.D., Marcus, S.I., Theodorou, H., et al. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, *130*, 805-808. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[84] Fletcher, C. E. (2004). Experience with peer assistance for impaired nurses in Michigan. *Journal of Nursing Scholarship*, *36*(1), 92-93. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[85] Mann, M. (1946). Alcoholics Anonymous: A new partner for hospitals. *The Modern Hospital*, January, (reprint).

[86] McInerney, J. (1970). The use of Alcoholics Anonymous in a general hospital alcoholism treatment program. *Medical Ecology and Clinical Research*, *3*(1), 22.

[87] Collins, G.B. & Barth, J. (1979). Using the resources of AA in treating alcoholics in a general hospital. *Hospital and Community Psychiatry*, *30*(7), 480-482. Collins, G.B., Barth, J., & Zrimec, G. (1980). Recruiting and retaining AA volunteers in a hospital alcoholism program. *Hospital and Community Psychiatry*, *32*(2), 130-132.

[88] Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, *24*(12), 839-841.

were also used as drug educators in the schools and as volunteers to "talk down" individuals entering hospitals with adverse drug reactions.[89]

Volunteer programs linked to addiction treatment programs were extensive in the 1960s and 1970s.[90] Recovering volunteers were prized for their skill at engaging and encouraging clients, their ability to serve as recovery role models, and their guidance in reducing the cultural, racial/ethnic, and class barriers that existed between clients and professional staff. Thirty-five percent of drug abuse programs surveyed during this period had 50 or more volunteers, and half of all volunteers in this period reported a desire to work in addiction treatment due to a personal or family addiction/recovery experience, with 16% explicitly identifying themselves as ex-addicts.[91] Former volunteers constituted 18% of all treatment staff and one-third of all non-degreed counselors in 1977.[92] In the late 1970s, financial resources to support volunteer programs were provided to local treatment programs in more than 27 states through the National Institute of Alcohol Abuse and Alcoholism's Volunteer Resource Development Program.

In spite of this support, the use of volunteers fell out of favor. This happened with the introduction of managed care and a shift in emphasis from inpatient to outpatient treatment in the 1980s and 1990s. At the same time, there was a move toward greater professionalization, regulation, and commercialization of addiction treatment that unfolded throughout the 1980s and 1990s.

In the 1960s and 1970s, volunteers were viewed as a panacea because they could address staff shortages. However, there were criticisms and concerns related to the time and costs involved in sustaining a volunteer program, the limited functions volunteers could perform, and problems related to reliability and poor management of relationship boundaries with clients.[93] In the transition to a professional addiction treatment workforce, recovering alcoholics and addicts often were employed or volunteered to serve as "patient instructors" of

---

[89] Termansen, P.E. (1973). Hospital program uses nonmedical volunteers to talk down drug users. *Hospital and Community Psychiatry*, *24*(6), 384. Kline, J.A. & Wilson, W.M. (1972). Ex-addicts in drug abuse prevention education. *Drug Forum*, *1*(4), 357-366. .

[90] The use of volunteer programs did vary by modality; one study found that 41% of therapeutic communities and 48% of other drug-free programs used volunteers, but that only 9% of methadone maintenance programs had volunteer programs. Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

[91] Aiken, L., LoSciuto, L., & Ausetts, M. (1981). *A study of volunteers in drug abuse programs* (DHHS Publication No. (ADM) 81-1147). Rockville, MD: National Institute on Drug Abuse.

[92] Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

[93] Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

physicians, nurses, and other traditional helping professionals.[94] Ironically, services that were provided by recovering volunteers in the early history of addiction treatment, e.g., serving as a "personal aid" to clients, "socializing with clients," and helping educate professionals about recovery, are now being revived in the "new" push for P-BRSS.

Soon we will address the role of the addiction counselor—a role that moved from a "paraprofessional" to professional status between 1965 and 1985—but it is noteworthy that many recovering people continued in non-clinical support roles throughout the modern history of addiction treatment. The formal advocacy for expanded recovery support roles in the growth of P-BRSS constitutes a long-overdue recognition of the importance of these roles and a refocusing on the function of non-clinical recovery support. The P-BRSS initiative is also leading to a revitalization or rebirth of recovery volunteer activities through alumni associations, recovery advisory councils, consumer councils, and formal volunteer programs.

Recovering People Working in Professional Roles in Addiction Treatment

Recovering physicians were among the earliest recovering people to fill professional roles in addiction treatment institutions. The Keeley Institutes, the largest of the nineteenth-century addiction cure institute franchises, hired more than 130 recovering physicians—most Keeley graduates—to administer their Bi-Chloride of Gold Cure.[95] Dr. T.D. Crothers, representing the mainstream inebriate asylums, strenuously rejected this practice, as evidenced by the following excerpt from his 1897 editorial in *The Journal of Inebriety*:

> *It is confidently asserted 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 any 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 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*

[94] Klein, R.F., Foucek, S.M., & Hunter, S.D. (1991). Recovering alcoholics as patient instructors in medical education. *Substance Abuse*, *12*(2), 82-89. Spickard, A., Johnson, N. P., & Burger, C. (1989). Learning through experience. *Alcohol Health and Research World*, *13*(1), 36-39.

[95] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W. (2000c). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases, 19*(2), 1-10.

work any length of time…Every reformed man as a rule will relapse, particularly if he follows the business of curing others.[96]

A "lay therapy" movement began in the early twentieth century through the work of a clinic, established by the Emmanuel Church in Boston, that combined religion, psychology, and medicine in the treatment of nervous and mental disorders. The clinic quickly developed a specialty in the treatment of alcoholism and used trained recovering alcoholics as lay psychotherapists. Noted lay alcoholism therapists such as Courtenay Baylor, Francis Chambers, and Richard Peabody pioneered this role.[97] Lay therapists worked within newly formed outpatient alcoholism clinics of the 1940s, and recovering AA members—Pat. C., Lynn C., Otto Z., Lon J., Fred E., and Mel B.—defined the first formal Counselor on Alcoholism positions within the emerging "Minnesota Model" at Pioneer House, Hazelden, and Willmar State Hospital. AA members who were physicians, nurses, and psychologists also began to fill service roles in newly opening alcoholism units in hospitals.[98] Recovering alcoholics also pioneered non-AA-oriented treatment and recovery philosophies during the mid-twentieth century.[99]

Recovering alcoholics and addicts were recruited heavily to fill helping roles in the new treatment programs of the 1960s. They filled roles in programs funded under federal anti-poverty, mental health, traffic safety, and industrial alcoholism initiatives, as well as within alcoholism clinics funded by state alcoholism authorities. The popularization of the recovering paraprofessional "alcoholism counselor" and the "ex-addict counselor" occurred in tandem with interest in the potential of paraprofessionals in other fields, such as education, law, mental health, public health, and criminal justice.[100] The mix of professionals and paraprofessionals in the alcoholism field of the 1960s triggered intense debate over the question, "Who is qualified to treat the alcoholic?"[101]—a debate we will discuss in depth shortly.

---

[96] Crothers, T.D. (1897). Reformed men as asylum managers. *Quarterly Journal of Inebriety, 19*, 79-81, Quote from pages 79-80.

[97] Baylor, C. (1919). *Remaking a man.* NY: Moffat, Yard & Company. Peabody, R. (1936). *The common sense of drinking*. Boston: Little, Brown, and Company. Strecker E. A. & Chambers, F. T., Jr. (1938). *Alcohol: One man's meat.* New York: The MacMillan Company.

[98] Anonymous (1952). I'm a nurse in an alcoholic ward. *Saturday Evening Post,* October 18, pp. 40-41, 111-116. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[99] McGoldrick, E. (1966). *The conquest of alcohol*. NY: Delacorte Press.

[100] Cressey, D.R. (1965). Social psychological foundations for using criminal in the rehabilitation of criminals. *Journal of Research in Crime and Delinquency*, 2(2), 49-59. Durham, E.L. (1974). St. Leonard's House: A model in the use of ex-offenders in the administration of correction. *Crime & Delinguency*, 20(3), 269-280. Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher.

[101] Krystal, H. & Moore, R. (1963). Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol*, *24*, 705-720.

The use of people in recovery in paid or volunteer roles was not always initiated out of the best intentions. Jim McInerney explains:

> *There are treatment programs that give lip service only to the prudence of employing AA member-alcoholism counselors. Prior to the days of greater enlightenment this was an appeasement tactic used to keep the AA community happy: this was true particularly in cases where the AA community happened to be a major source of referrals for the facility in question*.[102]

The use of recovering alcoholics and ex-addicts in new addiction treatment programs began as a necessity (given the lack of trained professionals willing to work in these settings), but rapidly became a fad.

> *It now appears that the ex-addict or "indigenous leader" has become vogue. The demands for ex-addicts to participate in treatment programs are becoming so numerous that the extent of an ex-addict's training and self-help experience is being overlooked. The demand is not for skilled, qualified manpower, but for the label "ex-addict." Thus anyone who once stuck a needle in his arm is coming to be regarded as possessing curative powers, or magic. The only requirement he must fill is that he no longer uses drugs*.[103]

Ex-addicts of varying levels of commitment and competence filled service roles in newly created drug abuse programs. Rhodes and White describe the earliest efforts in Illinois to bring ex-addicts into helping roles in the 1960s.

> *Each day, after the closing of the clinic, about 75% of the staff remained in the area to cop drugs from the addicts in treatment…With the exception of "Moses," there was total disrespect for the ex-addict staff. The street reputation of the majority of the staff carried over into the clinic and was not conducive to making positive changes in the client's lifestyle*…[It was quite some time before] *the role model concept was widely accepted and there was a core group of ex-addicts who were abstinent and "really taking care of business."*[104]

Rhodes and White go on to describe the closed world of the ex-addict counselor during these early days.

---

[102] McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield, IL: Charles C. Thomas Publisher, Quote from page 95.

[103] Deitch, D. & Casriel, D. (1967). The role of the ex-addict in the treatment of addiction. *Federal Probation*, 31, 45-47.

[104] Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman, quote from pages 1052, 1054.

> *…we have created a new society composed totally of ex-addicts….Our whole lives have become treatment oriented. Instead of re-entering the "normal" society, we have created an "ex-drug abuser" society. In fact, we have found that ex-addicts are still not accepted by society. This is recognized in our attempts to secure jobs, utilize facilities such as community recreational institutions and even some hospitals still look down on the ex-addict. This has caused ex-addicts to look to each other for social support, thus creating this sub-culture…ex-addicts are, in fact, an untouchable caste to most segments of society, whether abstinent or not*.[105]

As federal funds were channeled through states and local communities in the early 1970s, there was tremendous pressure to professionalize the roles of "alcoholism counselor" and "drug abuse counselor" via credentialing, certification, and licensure.[106] This triggered new addiction studies programs in colleges, universities, and private training institutes. Also noteworthy were efforts to organize the growing legion of recovered alcoholic and ex-addict counselors through professional counselor associations—most notably the National Addiction Services Guild (1971) and the National Association of Alcoholism Counselors and Trainers (1972).[107]

New funding for addiction treatment services also brought an influx of professionals into the emerging alcoholism field and drug abuse field. This created competition and conflict that split along multiple lines: recovered versus non-recovered, non-degreed versus degreed, black and brown versus white, non-privileged versus privileged.[108] Some recovering people in the field felt that ex-addicts were being colonized.

---

[105] Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman, quote from pages 1057, 1060.

[106] Banken, J.A. & McGovern, T.F. (1992). Alcoholism and drug abuse counseling: State of the art considerations. *Alcoholism Treatment Quarterly*, *9*, 29-53. Keller, D. S. & Dermatis, H. (1999). Current status of professional training in the addictions. *Substance Abuse*, *20*, 123-140.

[107] In contrast to other countries, there have been few efforts in the United States to organize active drug users or clients in treatment as a political force; in contrast, see Palm, J. (2006). The consumer, the weak, the sick, the innocent: Constructions of "the user" by the Swedish Users Union. In J. Anker, V. Asmussen, & D. Tops (Eds.), *Drug users and spaces for legitimate action* (NAD Monograph no. 49, pp. 159-182). Helsinki, Finland: Nordic Alcohol and Drug Council.

[108] Deitch, D.A. (1974). The end of the beginning: Dilemmas of the paraprofessional in current drug abuse treatment. In E. Senay & H. Alksne (Eds.), *Developments in the field of drug abuse: Proceedings of the national drug abuse conference* (pp. 1029-1036). Cambridge, MA: Schenkman.

> *…the ex-addict "paraprofessionals" are in an insecure position, limited in mobility, and living within a sophisticated but exploitative relationship with professional staff.*[109]

Some professionals entering the field during the early 1970s were very critical of paraprofessional staff. A 1972 article penned by a psychologist and physician suggested that ex-addicts were characterologically unsuited for the work of counseling; were prone to subjectivity, rigidity, and over-identification with the drug culture; and were simply trading dependency on drugs for lifelong dependency on a treatment institution.[110] They concluded:

> *It is our suggestion that the failure of current programs may be due, in part, to the misuse of ex-addict counselors as drug treatment personnel.*[111]

The titles "paraprofessional" and "subprofessional" conveyed some of the disdain with which recovering counselors were regarded.[112] The few career ladders that existed for early paraprofessionals in recovery suggested that their ultimate value would come only by abandoning their experiential roots and seeking further academic education and professional training.

Rivalries and conflicts within treatment programs increased as people with such varied backgrounds sought to find their niche.[113] Chappel, Charnett, and Norris suggested three factors that contributed to poor teamwork between paraprofessional ex-addicts and professionals: 1) the implied stigma in such professional labels as paraprofessional, ex-addict, recovered drug user, and non-degreed counselor; 2) struggles over status, power, and money; and 3) differences in philosophy and approaches to counseling.[114] Intra-program conflicts were often rooted in stereotypes, feelings of inadequacy, and the emotional stress inherent in addiction counseling among both groups of workers. They were also rooted in objective conditions visible to anyone working within

---

[109] Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman.

[110] Zimmerman, R. S. & Coughlan, A. J. (1972). The (mis)use of ex-addicts in drug abuse treatment programs. *Drug Forum*, *1*(4), 367-372. Suchotliff, L. & Seligman, E. (1974). The myth of the ex-addict staff. *Drug Forum*, *4*(1), 47-51.

[111] Zimmerman, R. S. & Coughlan, A. J. (1972). The (mis)use of ex-addicts in drug abuse treatment programs. *Drug Forum*, *1*(4), 367-372.

[112] Gusfield, J. (1982). Deviance in the welfare state: The alcoholism profession and the entitlements of stigma. *Research in Social Problems and Public Policy, 2*, 1-20. Staub, G. & Kent, L. (1973). Thoughts to ourselves. In G. E. Staub & L. M. Kent. (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas.

[113] Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, *24*(12), 839-841.

[114] Chappel, J.N., Charnett, C.V., & Norris, T.L. (1974). Paraprofessional and professional teamwork in the treatment of drug dependence. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 297-306). Cambridge, MA: Schenkman.

these environments: ex-addicts performed the same duties as professionals but worked longer hours and received far less than the wages professionals were paid. The issue of disproportionate pay for people in recovery has pervaded the modern history of addiction treatment and continues today.[115]

In 1974, David Deitch, an early pioneer within the therapeutic community movement, reflected on the state of the treatment field and the future of the ex-addict counselor.

> *There is no question that we are at the end of the beginning. Nor is there a question that, without adequate training, many of those who participated in making the beginning, will fade away in the end*.[116]

As the 1970s gave way to the 1980s, pressure built for recovering people working as addiction counselors to become certified, which in many states meant pursuing a college education. Studies from the early 1970s found that 70% of ex-addict counselors did not have a high school diploma or GED.[117] As Deitch predicted, many among the first generation of recovering counselors did not make the transition to a professionalized field of addiction counseling. As that transition progressed, terms like "paraprofessional" became less tenable and were dropped from the field's lexicon.[118] However, people in recovery without college degrees did continue to be hired as outreach workers, case managers, peer educators, recovery coaches, and research assistants in the addictions field and in addiction-related projects sponsored by mental health and child welfare agencies, AIDS service organizations, and religious organizations (1980s-present).

The percentage of American addiction counselors with recovery experience and the range of peer recovery support services in addiction treatment declined in recent decades. (See later discussion.) This decline occurred in tandem with the professionalization of the field and with a fee-for-service system that no longer paid for community education, outreach, crisis intervention, case coordination meetings, home visits to families, vocational/employment counseling, aftercare, or volunteer recruitment and training. This trend may be reversing itself due to growing interest in peer

---

[115] Olmstead, T. (2007). Why are recovering counselors paid less? *Substance Abuse*, *28*(1), 31-44. Olmstead, T.A., Johonson, J.A., Roman, P.M., & Sindelar, J.L. (2005). What are the correlates of substance abuse counselor salaries? *Journal of Substance Abuse Treatment, 29*, 181-189.

[116] Deitch, D.A. (1974). The end of the beginning: Dilemmas of the paraprofessional in current drug abuse treatment. In E. Senay & H. Alksne (Eds.), *Developments in the field of drug abuse: Proceedings of the national drug abuse conference* (pp. 1029-1036). Cambridge, MA: Schenkman.

[117] Bokos, P. J. (1974). Education and training for drug abuse paraprofessional staff. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1037-1040). Cambridge, MA: Schenkman.

[118] Rosenberg, C. (1982). The paraprofessional in alcoholism treatment. In E. Pattison & E. Kaufman, (Eds.), *Encyclopedic Handbook of Alcoholism* (pp.802-809). New York: Gardner Press.

recovery support programs. The recovery coach role, in particular, is spreading within addiction treatment and through special addiction-related service projects in allied fields (public health, public welfare, child welfare, and criminal justice). The use of recovering people within faith-based recovery ministries has also grown in tandem with new federal funding for faith-based recovery support services through the Access to Recovery (ATR) program. (See later discussion.)

All the recovery support roles filled by recovering people rested on a belief that recovery brought a depth of "experience, strength, and hope" that could be mobilized to help others seeking recovery. That people in recovery could offer a special level of empathy and respect is a foundational concept in the history of P-BRSS. (We will review the scientific status of that proposition later in this monograph.)

> *The drunkard is now regarded in a new light by the Washingtonians. 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 his as a brother...as a slave to appetite, and debased by passion—yet still as a man, our own brother.*[119]

> *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...*[120]

It is important to understand how the role of addiction counselor changed through efforts to professionalize this role. The "paraprofessional" era that spanned temperance missionaries, early twentieth-century lay therapists, and the paraprofessional counselors of the mid-twentieth century had many distinguishing elements that dissipated over the past three decades through the professionalization of the addiction counselor role.

Table 5 illustrates this author's views on some of the key transitions that distinguish the "paraprofessional" counseling (services provided primarily by people in recovery) era from era of professionalized addiction counseling (services provided primarily by degreed professionals—including recovering people who pursued advanced education and training). Like the differences and vulnerabilities laid out in Table 1, the paraprofessional and professional paradigms represent opposite ends of a continuum, with actual characteristics and practices in both eras existing along that continuum. (For further discussion of real and perceived differences between recovering and non-recovering addiction treatment staff, see Chapter 6, "Scientific Evaluation of Peer-based Services.")

---

[119] A Member of the Society. (1842). *The foundation, progress and principles of the Washingtonian Temperance Society of Baltimore, and the influence it has had on the temperance movements in the United States*. Baltimore: John D. Toy.

[120] Crowley, J. (1999). *Drunkard's progress: Narratives of addiction, despair and recovery*. Baltimore: Johns Hopkins University Press.

Table 5: Paradigms of "Paraprofessional" and Professional Addiction Counseling

Dimension	Paraprofessional Counseling Era	Professional Counseling Era
Primary Credential	Length and quality of personal sobriety (active program of recovery maintenance); history of service work in recovery community; passion for working with alcoholics/addicts; apprenticeship under recovery elders.	Pre-service college education, training, certification, and past professional experience; learning via professional training and professional supervision.
Foundational Knowledge	Experience-based knowledge of recovery and recovery community; knowledge of the individual/family highly valued.	Theory- and science-based knowledge of addiction; written treatment protocols; emphasis on adherence to evidence-based practices; knowledge about addiction and execution of clinical techniques.
Role Definition	Role ambiguously defined; generalist: performed variety of tasks and worked with all clients; clear expectation to be a recovery role model.	Core counselor functions defined; frequent role specialization by level of care, modality, activity, and client populations.
Skill Emphasis	Client engagement; focus on verbal communication and encouragement.	Client engagement; focus on conceptual (e.g., diagnosis, treatment planning) and writing skills.
Diagnosis	Emphasis on self-diagnosis by the client, or on diagnosis based on the paraprofessional's own experience.	Emphasis on knowledge of DSM diagnoses and patient placement criteria.
Status of Service Recipient	Member of organizational family and/or recovery community—a "friend," "brother," "sister."[121]	A "patient" or "client."
Degree of Power Differential	Minimal power differential; stance of staff toward most clinically deteriorated client: "There but for the Grace of God go I."	Great power differential between counselor and client; professional counselor seen as expert.
Style of Helping Interaction	Informal, open, and spontaneous.	More formal, personally guarded, and strategic.

[121] Some peer-based programs are attempting to break down the distance that has grown between the helper and helpee in addiction treatment: See the description of the "Friend's Connector" program in Klein, A., Canaan, R., & Whitecraft, J. (1998). Significance of peer social support for dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, *8*, 529-551.

Dimension	Paraprofessional Counseling Era	Professional Counseling Era
Teaching Style	Ranged from discussion Model (truth lies in the exploration of collective experience) to personal narrative (truth based in part on the helper's experience).	Didactic Model: Truth lies in the conveyance of scientific findings to clients by professional authorities through one-on-one persuasion, lectures, videos, and assigned readings.
Counselor Self-disclosure	Accessible and vulnerable; self-disclosure and storytelling an essential part of the art of counseling.[122]	Hidden and protected; self-disclosure discouraged as unprofessional and a potential breach of ethics.
Companionship	Perceived as a critical need in recovery and a legitimate form of recovery support provided by the counselor.	Companionship between counselor and client perceived as a breach of professional ethics.
Length of Service Relationship	Measured in months/years.	Measured in days/sessions.
Focus of Counseling Work	Focus on character and context: Helping client get out of self—connecting with pro-recovery resources and relationships beyond the self; focus on doing (accountability for working an active recovery program).	Focus on the "clinical": helping the client get into self—exploring painful developmental issues thought to cause addiction or impede the recovery process; greater focus on feeling (expiation of pain) and thinking (insight).
Ethical Guidelines	Folklore; group conscience; ethical landmines hidden; ethical breaches common.	Ethical codes clearly defined; heightened level of ethical sensitivity; preoccupation with management of appropriate boundaries in service relationships.
Service Documentation	Non-existent to minimal; nearly all time spent interacting with clients; emphasis on counselor's communication and relationship skills.	Burdensome and ever-increasing; decreasing amounts of time available to interact with clients; great emphasis on writing/recording skills.

It can be seen that many of the core characteristics of the helping relationship in addiction treatment changed through counselor professionalization and the broader evolution of addiction treatment as a cultural institution. The point is not to label these changes in categories of "good" or "bad" but to note

[122] Recovering addiction counselors perceive a much higher benefit to the client of counselor self-disclosure than do addiction counselors who are not in recovery. Mondlick, L.E. (1998). Certified substance abuse counselors' perceptions of the effects of self-disclosure of their recovery status on the therapeutic relationship with substance abuse clients. Dissertation, New York University. *Dissertation Abstracts International*, *59*(05B), 2156.

historically that many aspects of the "paraprofessional" era are now being revived through P-BRSS specialty roles.

Current Recovery Coaching Practices in the Public and Private Sectors

Recovery coaching—experience-based guidance through the transition from recovery initiation to recovery maintenance—is offered through four different organizational venues: 1) self-supported or publicly-funded recovery community organizations, 2) publicly funded addiction treatment programs or allied service organizations, 3) private addiction treatment programs, and 4) private organizations that once specialized in conducting pre-treatment interventions on a fee basis and are now expanding their services to include post-treatment monitoring and support.

Examples of recovery community organizations (RCOs) providing recovery coaching services include three organizations whose early funding came from the Center for Substance Abuse Treatment's Recovery Community Support Program. The El Paso Recovery Alliance is currently contracted with the state of Texas to conduct six months of recovery coaching for clients discharged from residential addiction treatment at a rate of $25 per recovery coaching session.[123]

The Association of Persons Affected by Addiction in Dallas, Texas is contracted through Value Options to provide group-based and individual recovery coaching for eight weeks following discharge from addiction treatment. Coaching services may be re-authorized for an additional eight weeks. The cost is $15 per 15-minute unit of individual recovery coaching and $27 per person per hour for group recovery coaching.[124]

The Connecticut Community of Addiction Recovery (CCAR) is contracted by the State of Connecticut to provide telephone-based recovery coaching to 2,500 individuals for 12 weeks following their discharge from addiction treatment. They are contracted at a rate of $108 per person for this service.[125] Many RCOs extend recovery coaching services far beyond the period for which they are being paid. For example, CCAR has been providing recovery coaching to some people for more than 150 weeks—far beyond the 12 weeks for which they are contracted. RCOs are using a mix of paid staffing models and volunteer models of providing recovery coaching services. These efforts in the public sector are triggering calls for regulations governing recovery coaching and the certification of recovery coaches.

[123] Personal communication with Ben Bass, September, 2008.
[124] Personal communication with Joe Powell, September, 2008.
[125] Personal communication with Phil Valentine, September 2008

Program Profile 4: Telephone Recovery Support (Hartford, CT) **Connecticut Community of Addiction Recovery**
Purpose: 1) to call a person in recovery once a week to "check in" and help the person maintain recovery, 2) to intervene early to re-stabilize recovery following lapse/relapse episodes.
Service Elements: After signing a consent form provided by either a treatment provider or a sober house, or at a local recovery community center, the person is called once a week for at least 12 weeks by a trained volunteer, who provides recovery coaching. The calls are made from local recovery community centers. Telephone support started out in Connecticut in 2005, with volunteers from CCAR's Willimantic Recovery Community Center calling 22 persons in recovery to offer support. Today, telephone support is being provided to 371 individuals on a weekly basis from all four Recovery Community Centers.
Survey Outcomes: 1) During the lifetime of the program (2005-present), volunteers have placed more than 36,131 calls to 1,803 unduplicated "recoverees." 2) Of those calls, volunteers were able to make contact 12,129 times (33.6% of the time). 3) Of those reached, 96.4% reported that they had used other supports for their recovery, and 96.7% reported being "in recovery." 3) 2.6% of those contacted reported having relapsed, and, of those, 59.4% were able to be helped back into recovery.
Service Lessons: 1) Volunteers report that they get more out of making the calls than do those receiving the calls. 2) Volunteers do not have to be in recovery to make the calls. The fact that the call comes from someone who cares about how the recovery process is going is enough to make it helpful. 3) A simple program can generate phenomenal results.
For More Information: Contact Kevin Hauschulz at kevin@ccar.us or 860-218-9531

Telephone-based recovery services hold great promise for individuals and families as an independent service or as an adjunct to addiction treatment. Given the growth of a youth-based "text culture," it is surprising that there are so few reports of text massaging being investigated as a medium of recovery support service delivery for adolescents.

In the public sector, programs are offering a range of recovery coaching services that include pre-treatment outreach, in-treatment case management, and post-treatment monitoring and support.[126]

[126] Ryan, J. P., Marsh, J. C., Testa, M. F., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services. *Social Work Research*, *30*(2), 95-107. Loveland, D. & Boyle, M. (2005). *Manual for recovery coaching and personal recovery plan development.* Retrieved August 18, 2008 from http://www.bhrm.org/guidelines/RC%20Manual%20DASA%20edition%207-22-05.doc.

Program Profile 5: New Pathways Project (Philadelphia, PA)[127] **(Assertive Street and Community Outreach)**
Purpose: Reaching the unreachable—those whose pain is so deep and so profound, and whose lives are so chaotic, that triggering hope for recovery takes assertive and sustained involvement; reducing the risk of HIV infection/ transmission among minority men and women by facilitating access to addiction treatment and supportive social services.
Service Elements: Street outreach in areas of high drug activity and outreach in key institutions (including housing shelters, church-based meal programs, community corrections facilities, halfway houses and recovery homes, health fairs, advocacy groups) provided by staff and peer volunteers (Pathfinders); case management; pre-treatment counseling to enhance treatment readiness; pre- and post-treatment educational/support group meetings; Consumer Advisory Council.
Service Volume/Status: 15,000+ outreach/educational contacts; focused case management and pre-treatment counseling with 200+ adult men and women per year.
Service Outcomes: Preliminary outcomes for 128 clients reveal reduction in binge drinking in past 30 days from 53% to 19%; reduction in drug use in past 30 days from 100% to 37%; 44% of clients entered treatment—40% of these for first time; HIV testing in prior six months rose from 32% to 70%; HIV+ clients receiving medical care for HIV rose from 44% to 100%.
Service Lessons: People who would not otherwise seek addiction treatment can be engaged through assertive outreach, case management, and recovery coaching. People can recover under the most extreme and adverse conditions.
For More Information: Contact Eugenia Argires (eargires@phmc.org)

Recovery coaching in the private addiction treatment sector is typified by two well known treatment institutions.

Since 1996, the Betty Ford Center has provided a post-treatment, telephone-based Focused Continuing Care (FCC) program to treatment graduates. The FCC program entails meeting with the recovery coach during primary treatment, being oriented to FCC, signing a contract for participation in FCC, and participating twice a month in monitoring/support calls for the first three months and one call per month for up to one year.[128]

Hazelden has launched MORE (My Ongoing Recovery Experience)—a continuing care service that includes educational materials, workshops and retreats, a personal recovery coach who provides monitoring and support for the

[127] Philadelphia Health Management Corporation (2008). New Pathways Project: A community-based model for building recovery capital. Unpublished manuscript. Bond, L. & Argires, E. (2008). *New Pathways Project*. Power-point Presentation.

[128] Cacciola, J. S., Camilleri, A. C., Carise, D., Rikoon, S. H., McKay, J. R., McLellan, A. T., et al. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford Center Focused Continuing Care protocol. *Addictive Behaviors, 33*, 1208-1216.

first three months after treatment, and web-based recovery education and recovery check-ups. Like the Betty Ford Center, Hazelden's enhanced continuing care services are provided to all patients completing primary treatment, and the cost for these continuing care sessions is usually built into the basic charge for inpatient services.[129]

The most cursory search of the Internet reveals an array of private, fee-based recovery coaching services. The early impetus of these services came from private practitioners who began offering "back-end" monitoring, case management, and recovery coaching to supplement their "front-end" intervention services. Most began this extension of services as part of professional assistance programs for pilots, physicians, nurses, pharmacists, and attorneys and then extended these monitoring and support services to clients not in such professional roles. Some of the more prominent of those offering private recovery coaching include Intervention 911; Intervention 180; Southworth and Associates; and Recovery Support Services, LCC. There is even an association of recovery coaches—Recovery Coaches International, founded in 2005.

Private recovery coaches—also referred to as sober coaches, sober mentors, recovery companions, personal recovery assistants, and sober escorts—offer a wide menu of recovery support services, including:

- sober escort/transport to and from a treatment center;
- in-home meetings;
- live-in recovery support;
- telephone- or Internet-based recovery coaching;
- oversight of drug testing;
- linkage to recovery support meetings (arranging sponsorship, transportation to meetings, co-attendance at meetings, facilitation of virtual recovery groups, facilitation of daily readings, and step work);
- sober companionship;
- meetings with families; and
- guidance on daily journaling, leisure activities, and daily nutrition.

Private recovery coaches generally offer bundled service packages that reflect different levels of monitoring and support intensity. These can range from weekly progress reports on recovery activities faxed to the coach, with monitoring and follow-up if no fax is received, to more enhanced packages involving regular visits or calls to review the client's status, supervision of random urine screens, meetings with family members and co-workers, active referral to needed resources, ongoing case management, and extended time periods for monitoring. These packages can range from $1,000-$6,000 per year for basic services and up to $10,000 per year for enhanced monitoring options (plus the cost of drug testing) and such ancillary service roles as those of sober escort to and from treatment or live-in recovery coach. It is common for private services to split the monitoring and active recovery coaching functions between different contractors.

[129] Duda, M. (2005). Hazelden to launch unique continuing care program. *The Voice*, Summer.

The extent to which private fee-for-service recovery coaching constitutes P-BRSS is open to question, as it is unclear the percentage of recovery coaches who are in personal recovery and who use a peer-based versus professional philosophy to guide service delivery. Surveys comparing private sector and public sector addiction treatment programs note that staff members in the private sector have higher levels of education, but recovery representation has not been reported in these studies.[130] Recovery coaching, like addiction counseling before it, is being promoted as a "new profession," with recovery coach training and certification programs advertised at fees exceeding $3,000.[131]

The ideal length of monitoring and support advocated by recovery coaches whom the author has interviewed is usually identified as five years. This is based on the length of the early professional monitoring model, but nearly everyone interviewed reported average lengths of monitoring of less than one year—a function of limited time periods of reimbursement for monitoring services by third-party payors and difficulty sustaining clients through the monitoring and support process.

In the next chapter, we will discuss the key theories and principles that guide the design and delivery of P-BRSS.

[130] Rodgers, J. H. & Barnett, P. G. (2000). Two separate tracks: A national multivariate analysis of differences between public and private substance abuse treatment programs. *American Journal of Drug and Alcohol Abuse, 26*(3), 429-442.

[131] Crossroads Coaching advertised Recovery Coaching Certification Program of six modules offered at a fee of $3,100.

Chapter Three

The Theoretical Foundations of Peer-Based Recovery Support

Summary of Key Points

- 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 key 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.

A number of academic disciplines have set forth theories about the active ingredients of mutual peer support. Magura and colleagues' review of these theories is outlined in Table 6.

Table 6: Academic Theories on Mutual Peer Assistance

Theoretical Framework	Proposed Active Ingredient of Mutual Helping	Psychological/Social Process	Proponent
Social Psychology	Commitment to Change	Helping others strengthens one's own commitment to change and anchors key ideas and activities that support change.	Reissman, 1965[132]
Group Psychotherapy	Altruism	Helping others serves as a personal antidote to self-absorption.	Yalom, 1985[133]
Social Learning Theory	Enactive Attainment	Helping others spurs personal change by enhancing the self-efficacy and self-esteem of the helper.	Bandura, 1995[134]
Cognitive Consistency Theory	Resolution of Ambivalence	Helping others forces resolution of one's own ambivalence about changing.	Petri, 1996[135]
Self Psychology	Alteration of Personal Identity	Helping others strengthens one's own identity as a changed person.	Kaplan, 1996[136]

P-BRS does not begin with theory-building and scientific testing. It emerges from the collective experience of communities of recovering people. There are, however, certain ideas and principles that one consistently hears from those delivering and receiving P-BRS. The purpose of this chapter is to summarize briefly the core ideas upon which peer recovery support services have been and are being constructed. The question of the extent to which these

[132] Riessman, F. (1965). The "helper" therapy principle. *Social Work*, April, pp. 27-32.
[133] Yalom, I. (1985). *The theory and practice of group psychotherapy* (3rd edition). New York: Basic Books.
[134] Bandura, A. (1995). *Self-efficacy: The exercise of control*. New York: Freeman.
[135] Petri, H.L. (1996). *Motivation* (4th edition). Pacific Grove, CA: Brooks/Cole.

[136] Kaplan, H.B. (1996). *Psychosocial stress*. New York: Academic Press.

propositions are supported by scientific studies will be addressed in chapters four through seven.

"Nothing about us without us"

The essence of empowerment is the ability of people to participate in decisions that affect their lives and to join together with others in similar circumstances to advocate on issues of common concern. Peer recovery support is an expression of such empowerment. P-BRS rests on the proposition that recovering people have a right to be involved in and serve in leadership positions in the planning, design, delivery, and evaluation of addiction treatment and recovery support services. P-BRS is a testimony that recovering people can be part of the solution to AOD problems at personal, family, community and cultural levels.

Program Profile 6: Recovery Advisory Committee (RAC, Philadelphia, PA)[137]
Purpose: To provide a vehicle through which recovering individuals and their families can provide input into recovery-focused behavioral health systems-transformation efforts in the City of Philadelphia. (Established May, 2005)
Service Elements: 1) RAC member recruitment; 2) Regular RAC meetings; 3) RAC policy statement and recommendations.
Service Outcomes: 1) Development of recovery definition and core recovery values; 2) refinement of recovery vision to guide behavioral health systems transformation; 3) input into system-change priorities; 4) planning peer leadership development initiatives; 5) currently evaluating outcomes of RAC's first three years of operation.
Service Lessons: 1) Importance of broad representation of communities of recovery; 2) importance of balance between individuals and family members in recovery; 3) importance of authenticity of recovery representation, e.g., representatives who are not also professional stakeholders in the system; 4) value of preparing recovery representatives in ways of participating with professionals; and 5) value of outside facilitation to ensure active and full participation by everyone.
For More Information: Contact Joan King at jking@netreach.net or 215- 721-7409

[137] Personal communication with Joan King, November, 2008.

Program Profile 7: Recovery Foundations Training (Philadelphia, PA)[138]
Purpose: To increase participants' understanding of recovery from behavioral health disorders. The training is available to staff of the Department of Behavioral Health/Mental Retardation Services, persons in recovery, family members, community-based service providers, and members of the larger community.
Service Elements: A 2-day training program that provides: 1) an overview of recovery principles, 2) key elements of recovery oriented care, and 3) application of recovery concept to each participant's service/support role.
Service Volume/Status: As of November, 2008, 64 Recovery Foundations Training sessions have been conducted for more than 1,600 participants.
Service Outcomes: 1) Provided concrete examples of what individual/family recovery looks like and how it can be supported, 2) enhanced relationship building between individuals/families in recovery and multiple service providers, 3) forged a common language related to recovery and recovery support services, 4) created a recovery-focused learning community, and 5) affirmed hope for long-term recovery.
Service Lessons: 1) 2-day format was an obstacle to participation for some constituencies; alternative formats could be utilized; 2) wonderful vehicle for relationship building and mutual learning between professional and recovery communities.
For More Information: Contact Michelle Khan Michelle.Khan@phila.gov or at 215-685-4768.

Program Profile 8: Peer Leadership Academy (PLA, Philadelphia, PA)[139]
Purpose: To train individuals and family members in recovery to assume leadership roles in Philadelphia's recovery-focused systems-transformation process
Service Elements: The 26-week training program contains such modules as Listening in Leadership, Identity and Diversity, Negotiating Paradigms and Terms, The Win/Win Strategy, Building Relationships, Resolving Conflicts, The Interpersonal Dimension of Leadership, Analyzing Current Reality; Mental Models Toward Current Reality, Systems Thinking, Strengths Theory and Team Building, Shared Vision, Team Learning, etc.
Service Volume/Status: Effort spans recovery from addiction, mental illness and co-occurring disorders; 60 recovering people have been trained by four faculty members; college credits are provided for completion of training.

[138] Personal communication with Michelle Khan, November, 2008
[139] Personal communication with Bev Haberle, December, 2008

Peer Leadership Academy (Continued)
Service Outcomes: Survey of graduates revealed a total of 740 hours of voluntary community service in past nine months—a 40% increase over pre-training levels; graduates reported a total of 40 community presentations made since completion of training.
Service Lessons: 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 volunteers' 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

Program Profile 9: A New Day: A Celebration of Recovery (Philadelphia, PA)
Purpose: Conduct a one-day conference planned, organized, delivered, and evaluated by people in recovery for people in recovery; celebrate the growing role of the peer recovery culture in the transformation of Philadelphia's behavioral health care system.
Service Elements: 1) 16 focus groups held throughout the city to determine desired conference agenda; 2) people in recovery serving as facilitators and presenters; 3) national keynote speakers (John Lucas and Vince Papale); 4) ten concurrent workshops on such topics as wellness, advocacy, housing opportunities, storytelling, family support, leadership training, and cultural competency; 5) formal lunch; 6) Recovery Champion awards to individuals and community-based organizations; 7) recovery talent show/exhibit (arts, crafts, music, dance); and 8) a recovery celebration dance.
Service Volume/Status: 1,000 participants, with many turned away due to space limitations.
Service Outcomes: 1) Wonderful means of celebrating and elevating importance of peer culture in systems-transformation processes; 2) followed up with Valuing the Village Conference held in November, 2008, focusing on health disparities.
Service Lessons: Following were critical to conference success: 1) stakeholder inclusiveness in planning group, 2) focus groups to generate interest and focus of conference content, 3) recovery volunteers who helped manage the event.
For More Information: Contact Jennifer Dorwart at JDorwart@pmhcc.org or 267-825-6861

The Wounded Healer Tradition

People who have survived a life-altering disorder or experience may develop special sensitivities, insights, and skills to help others in similar circumstances.

> *The term* [wounded healer] *refers to a person whose personal experience of illness and/or trauma has left lingering effects on him—in the form of lessons learned that later served him in ministering to other sufferers, or in the form of symptoms or characteristics that usefully influenced his therapeutic endeavors.*[140]

The idea and value of the "wounded healer" has deep roots in religion, from beliefs that the shaman's healing powers emanate from his or her own emotional/spiritual death and rebirth to the Christian view of Jesus as the "suffering servant." The wounded healer tradition is also embedded within the history of medicine and psychiatry. Sigmund Freud and Carl Jung suggested that the psychotherapist must deeply understand his or her own wounds to heal others effectively.[141] The source of healing for wounded healers is not based on what they have been taught, but on who they are as people and the resources they can draw from within themselves and their communities.[142]

But in the context of P-BRSS, must these inner resources include recovery from addiction? In his history of Alcoholics Anonymous, historian Ernest Kurtz noted the many non-alcoholics who had played important roles in the history of AA—Dr. Silkworth, Sister Ignatia, Sam Shoemaker, Willard Richardson, Frank Amos, Dr. Harry Tiebout, and Father Ed Dowling, to name only a few. Here is how Kurtz described these individuals.

> *They were not alcoholic, but they did all have something in common: each, in his or her own way, had experienced tragedy in their lives. They had all known kenosis; they had been emptied out; they had hit bottom....whatever vocabulary you want. They had stared into the abyss. They had lived through a dark night of the soul. Each had encountered and survived tragedy*.[143]

The "kinship of common suffering" can transcend such labels as "alcoholic" and "non-alcoholic." The most important dimensions of the peer relationship are emotional authenticity, humility, and the capacity to offer support from a position of moral equality. One's addiction/recovery career may be of secondary value, and, as we shall see, does not in itself ensure such traits.

In communities undergoing recovery-focused transformation of their behavioral health care systems, the increased interaction between people in recovery and traditional professionals without a history of addiction results in an inevitable diminishment of the social space between the two groups. These interactions inevitably produce a sense that "we are all in recovery." It remains to be seen whether this marks a pathway of empathy and community inclusion—an important element in the destigmatization of addiction and recovery—or a dilution

---

[140] Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine*, *75*, 1-36.
[141] Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine*, *75*, 1-36.
[142] Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.
[143] Kurtz, E. (1996). Spirituality and recovery: The historical journey. *The Blue Book*, 47, 5-29.

of the meaning of recovery that might weaken the essence of peer recovery support, its future as a social movement, and its role in behavioral health care.

The Power of Calling (Amends in Action)

The zeal to help others that recovering people feel reflects a deep sense of personal purpose and a means of making amends (restitution and reparations) for past addiction-related harm to others. The courtship with death that accompanies severe alcohol and other drug dependency often generates survival guilt in early recovery and a tendency to question why one's life was spared when it so easily might have been lost. One common answer to this question is that one was spared to bring a message of hope to others who are still suffering, or that one has an important role to play in preventing others from following the same path. Such sense of destiny has propelled service work within recovery fellowships and through the roles of recovery coach and addiction counselors, and has inspired recovering people to bring their existing occupational roles or gifts to the service of the recovery cause.

> *I can sympathize with and appreciate the condition of the poor inebriate. Have I not been one of their number? I now have an object in life to reform men.* (Thomas Doutney, Nineteenth-Century Temperance Lecturer)[144]

> *After a month of daily increasing happiness, I was struck with an overwhelming sense of gratitude....I felt I must do something in return. When I learned about the A.A. ward at Knickerbocker [hospital] I knew what that something would have to be....I can't convey how much it means to see the transformation in people....To know that I had some small part in this rebirth is a blessing far beyond what I deserve.* (Teddy R., a recovering nurse in AA, describes her motivation for seeking work in one of the earliest hospital-based alcoholism units in New York City.)[145]

Zemore[146] aptly describes such service work as a "behavioral manifestation of a spiritual orientation."

The calling in recovery to help others can also serve as a form of restitution and reparation for past injuries to others.

> *Now I can give back to the people and cities I helped poison.* (Gerard Wallace, peer educator in Oakland, CA)[147]

---

[144] Doutney, T. (1903). *Thomas Doutney: His life, struggle and triumph*. Battle Creek, MI: The Gage Printing Company, Limited.

[145] Anonymous (1952). I'm a nurse in an alcoholic ward. *Saturday Evening Post,* October 18, pp. 40-41, 111-116.

[146] Zemore, S.E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, *100*(4), 447-450.

Program Profile 10: Amends in Action (Philadelphia, PA)[148]
Purpose: Reduce addiction-related social stigma by putting a positive face on recovery; increase public visibility of people in long-term recovery; provide a venue for restitution and community service by people in recovery.
Service Elements: 1) Food bank volunteer crews, 2) Habitat for Humanity volunteer crews, 3) nursing home visitation/activities, 4) community clean-up, 5) Suitcases for Recovery (for foster children), and 6) Philadelphia's Big Give (gifts for people in early recovery, e.g., diapers for the children of mothers in recovery).
Service Volume/Status: 120 people have participated in eight Amends activities during the 2008 calendar year.
Service Outcomes: 1) Increased self-esteem from acts of restitution and giving, 2) increased ownership of one's own recovery, 3) increased integration of people in recovery with the larger community—less estrangement and alienation.
Service Lessons: 1) Service ideas must come from volunteers, 2) service activities must be well planned, 3) service processes must provide opportunities for mutual support and fellowship among volunteers.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

A consequence of this sense of calling that pervades peer-based services is an ambivalence or outright distrust of accepting money for such support. Each recovery mutual-aid fellowship and each recovering person accepting a paid position to provide recovery support has had to work out his or her own philosophy on this issue. The results have included a preference for volunteerism or an emphasis on the importance of distinguishing between what one does as voluntary "service work" ("giving back") and what one provides as a paid service.[149]

EXPERIENTIAL KNOWLEDGE

Addiction counseling and P-BRSS rest on two overlapping but potentially conflicting traditions of authority: professional knowledge and experiential knowledge.[150] The former is knowledge acquired from outside of self—

[147] Galindo, L., Maginnis, T., Wallace, G., Hansen, A., & Sylvestre, D. (2007). Education by peers is the key to success. *International Journal of Drug Policy*, *18*(5), 411-416.

[148] Personal communication with Bev Haberle, December, 2008.

[149] A.A. Guidelines for A.A. Members Employed in the Alcoholism Field. (ND). New York: General Service Office, Alcoholics Anonymous.

[150] Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, *50*, 445-456. Brown, B.S. (1993). Observations on the recent history of drug user counseling. *The International Journal of the Addictions*, *28*(12), 1243-

information passed from master to apprentice through traditions of observing, testing, and thinking about a phenomenon. The latter is knowledge from inside—wisdom acquired by directly experiencing a phenomenon. Experiential knowledge is pragmatic—"concrete, specific, and commonsensical"—as opposed to theoretical or scientific.[151]

The experiential knowledge upon which P-BRS rests is wisdom drawn from one's lived experience of recovery and the knowledge acquired by living in a community of shared recovery experience—a way of knowing quite different from the knowledge gained through research and reasoning.

> *They* [drunkards] *fully understand each other's language, thoughts, feelings, sorrows, signs, grips, and passwords, therefore yield to the influence of their reformed brethren much sooner than to the theorists who speak in order that they may receive applause*. (D. Banks McKenzie, Founder of the Appleton Temporary Home)[152]

This difference in worldview is so significant that people in recovery have long used special terms to designate those who have not had addiction/recovery experiences (*earthlings*, *civilians*, *normies*). At its extreme, the value of experiential knowledge over professional knowledge (knowledge gained through observation, scientific study, and rational analysis) can be so strongly extolled as to suggest that *only* those who have experienced addiction and recovery can effectively counsel the addicted. The following, drawn from an addiction counseling trade journal, typifies this view:

> *But there can be no middle ground. The primary care giver in the alcoholism treatment center has to know what he/she is talking about and that means they have to have lived through the misery they hope to somehow spare for others. They cannot understand what their patients have gone through if they have not gone through that very same thing*.[153]

The counter position, typified in the 1963 Kystal-Moore debate, "Who is qualified to treat the alcoholic?" states that only those with advanced professional education are qualified to treat those suffering from addiction.

> *Of the disciplines now working with alcoholics only some psychiatrists, social workers and psychologists seem to satisfy the criteria of adequate preparation for treating the emotional problems at hand….The former problem drinker, however, who controls his drinking on the basis of his*

1255. Kurtz, L.F. (1984). Ideological differences between professionals and A.A. members. *Alcoholism Treatment Quarterly*, 1(2), 73-85.

[151] Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, *50*, 445-456.

[152] McKenzie, D. (1875). *The Appleton Temporary Home: A record of work.* Boston: T.R. Marvin & Sons.

[153] Gallagher, D. (1990). The case in favor of recovering counselors. *C.D. Professional*, *8*(1), 21.

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.[154]

Polarized debates between these ways of knowing arise periodically in the addictions field. However, neither having successfully overcome an addiction nor having earned an academic degree ensures one's ability to help others achieve and sustain recovery from addiction. (See studies reviewed in chapter six.) Each offers a different foundation upon which recovery assistance can be extended.

Where professionals extol the superiority of particular conceptual frameworks or particular methods of treatment, recovery advocates have emphasized that the attitude and relationship in which help is offered is more important than theory or technique.[155] Where these two worlds meet is in the agreement that there are essential traits and relational qualities that transcend knowledge, skills, competence, and access to needed resources, and that enhance service outcomes with those addicted to alcohol and other drugs. These include:

- interest/caring,
- warmth/rapport/trust,
- genuineness/sincerity,
- empathy/understanding,
- tolerance/acceptance,
- caring/non-possessiveness,
- perceptiveness/sensitivity,
- honesty/candor,
- firmness/fairness/flexibility, and
- immediacy/concreteness/common sense.[156]

These traits and dimensions appear to be common to all helping relationships.[157] P-BRSS are founded on the premise that the nature of the

---

[154] Krystal, H. & Moore, R. (1963). Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol*, *24*, 705-720.

[155] Mann, M. (1973). Attitude: Key to successful treatment. In G. E. Staub & L. M. Kent (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas. McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield: IL: Charles C. Thomas Publisher.

[156] Ottenberg, D. (1977). Traditional and nontraditional credentials in addictive problems: A dispatch from the battlefield. *The Addiction Therapist, 2*(1), 56-63. Lemere, F., Williams, R., Scott, E., Bell, R, Falkey, D., & Myerson, D. (1964). Who is qualified to treat the alcoholic? Comments on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol, 25*, 558-572. Wolf, S. (1983). Criteria for effectiveness: Recovered professionals as counselors. *Focus on Alcohol and Drug Issues*, *6*(3), 22, 28.

[157] Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Counseling Psychology*, *2*, 95-103. Truax, C. B. (1963). Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction.

helper and the helping relationship are more important than the source of authority upon which the helper draws. The traits and abilities of natural helpers are not contingent upon training and education, although such experiences can enhance or erode such natural assets.[158]

Different ways of knowing may match the learning styles of different people and may be of benefit to the same individuals/families at different stages of long-term recovery. This stands as a counter-argument to those who say these ways of knowing are incompatible, as suggested below.

> *It is our thesis that the future of alcohology will have to be established along either craft lines, exemplified by the paraprofessional alcoholism counselor, or scientific lines, embodied by the professional scientist. Because the defining properties and operational principles required for membership in a craft are different from those of a science, a détente would be difficult to achieve. The point is not that either approach is superior, but that marriage of the two prevents growth and progress. The synergism that is created acts in a negative rather than complementary way*.[159]

As traditional professionals entered the addictions treatment field in large numbers in the 1970s, they alleged that reliance on experiential knowledge was restraining the maturation of the field and blamed this state of affairs on the influence of AA.

> *Clinical treatment is not the logical outgrowth of scientific discoveries but instead remains an encapsulated body of theories and shopworn slogans that are apparently immune to the outcome of scientific research. Personal investment and the lack of openness to new findings and fresh conceptualizations are the hallmarks of the typical alcoholism treatment setting*.[160]

> *Alcoholics Anonymous' continued domination of the alcoholism treatment field has fettered innovation, precluded early intervention, and tied us to a treatment strategy, which, in addition to reaching only a small portion of problem drinkers, is limited in its applicability to the universe of alcoholics*.[161]

Journal of Counseling Psychology, *10*, 256-263. Carkhuff, R. & Truax, C. (1965). Lay mental health counseling: The effects of lay group counseling. *Journal of Counseling Psychology, 29*, 426-431.

[158] Wolf, S. (1974/1975). Counseling—for better or for worse. *Alcohol Health and Research World*, *Winter*, 27-29.

[159] Kalb, M. & Proper, M.S. (1976). The future of alcohology: Craft or science. *American Journal of Psychiatry*, *133*(6), 641-45.

[160] Kalb, M. & Proper, M.S. (1976). The future of alcohology: Craft or science. *American Journal of Psychiatry*, *133*(6), 641-45.

[161] Tournier, R. E. (1979). Alcoholics Anonymous as treatment and as ideology. *Journal of Studies on Alcohol*, *40*, 230-239. For articles countering the contention that core ideas from AA have retarded progress by claiming a singular view of alcoholics and an exclusive

Critics of peer recovery support suggest that peer helpers lack objectivity and that relying on one's experiential history may inhibit the ability to understand individual needs and differences. Advocates of P-BRSS respond that the potential for experiential bias is no different from the personal and ideological biases that professionals bring to the helping process, and that the peer's lack of theoretical bias is an advantage.

> *…the paraprofessional's lack of investment in a particular theoretical framework or diagnostic rubric allows him to be open to undistorted observation and to be free from the need to place an interpretation on behavior or thought. Further, his lack of theoretical bias allows him to think of the patient as a total person and to plan for his needs beyond psychotherapy*.[162]

The key tenets of P-BRSS include the following: 1) any form of bias can undermine the helping relationship, 2) bias is innately human and unavoidable, and 3) bias can be recognized and actively managed via self-knowledge and competent supervision, to minimize its potential harm to those receiving P-BRSS. Trading personal bias for theoretical bias via the professionalization of P-BRSS is not an advancement that will widen the doorways of entrance into recovery.

CHRONIC ILLNESS AND PEER SUPPORT

The course and outcome of chronic illnesses are profoundly influenced by the peer support available to individuals and families experiencing the prolonged effects of such illnesses. Addiction has long been characterized as a chronic illness,[163] and recent research confirms that the course and outcome of severe AOD problems closely resemble those of Type 2 diabetes mellitus, hypertension, and asthma.[164] However, addiction has been treated through two models that, until recently, have lacked a focus on long-term recovery support. The first is an acute-care model of intervention focused on brief biopsychosocial stabilization followed by termination of the service relationship. This model is typified by brief outpatient or inpatient/residential treatment programs. The

---

pathway of recovery, see: Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. *Alcoholism Treatment Quarterly*, 20 (3/4), 5-40. Miller, W. & Kurtz, E. (1994). Models of alcoholism used in treatment: contrasting AA and other perspectives with which it is often confused. *Journal of Studies on Alcohol, 55*(2), 159-166.

[162] Talbott, J. A., Ross, A. M., Skerrett, A. F., Curry, M. D., Marcus, S. I., Theodorou, H., et al. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, *130*, 805-808.

[163] White, W. L. & McLellan, A. T. (2008). Addiction as a chronic disorder: Key messages for clients, families and referral sources. *Counselor, 9*, 24-33.

[164] McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695.

second is a palliative care model whose primary focus has been on reduction of harm to society. This model does not usually include sustained peer recovery support services or assertive linkage to communities of recovery. This approach is typified by methadone treatment programs that offer few ancillary services.[165]

Evaluations of these acute-care and palliative-care models reveal significant problems in attraction and retention; inadequate scope, duration, and intensity of services; weak linkages to communities of recovery; and poor continuing care participation rates. People completing addiction treatment are precariously balanced between recovery and re-addiction in the weeks and months following discharge, and current models of intervention are plagued by high post-treatment relapse and re-admission rates.[166]

Recovery is not fully stable and durable (the point at which the risk of future lifetime relapse drops below 15%) until after 4-5 years of continuous sobriety.[167] Assertive linkage to communities of recovery and post-treatment continuing care that include regular recovery check-ups (monitoring, support, and, when needed, re-intervention) enhance long-term recovery outcomes[168] but are not routinely provided to those completing addiction treatment. All of these findings support experimentation with pre-treatment, in-treatment, and post-treatment peer recovery support services.

Chronic disorders are difficult to experience and to treat because of their complex etiology, prolonged course, unpredictable ebb and flow of symptoms, lack of a definitive cure, substantial changes in lifestyle required for effective management, and progressive drain of personal and family emotional resources. Dr. Max Weisman made this point in the early 1970s in defense of including recovering peers in the treatment of alcoholism.

> *There is a whole group of chronic illnesses where changes in patient's life style, attitudes and behavior are critically necessary for effective recovery and rehabilitation to take place….Diseases like diabetes, emphysema and tuberculosis, cardiac pathologies, arthritis and numerous others, for*

---

[165] White, W. & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

[166] Scott, C. K., Foss, M. A., & Dennis, M.L. (2005b). Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, *28*(Supplement 1), S63-S72. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

[167] White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

[168] 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. McKay, J. R. (2005a). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*(11), 1594-1610. White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

some considerable time have had their para-professionals….Alcoholism has been a late-comer.[169]

A premise for the management of all chronic illnesses, and for P-BRSS in particular, is the importance of continuity of support over an extended period of time. Addiction treatment in the United States is often referred to as a "system" of care, but, in reality, there is no system. Reimbursement based on discrete service units has resulted in a scarcity of connective tissue among treatment organizations and among levels of care within the same organization. There have existed thousands of self-encapsulated service units, but these could hardly be called a system of care.[170]

The absence of a system undermines recovery initiation and stabilization and the successful transition to recovery maintenance. Each level of care and program has its own philosophy and service protocol that may or may not be congruent with levels of care that precede or follow it. Therapeutic alliance established with a helper in one level of care is not easily transferred to the next level of care, resulting in high attrition in the movement of individuals and families across levels of care. The development of P-BRSS, like case management before it, is in part an effort to create continuity of contact over time and across levels of care in a primary recovery support relationship.

CHARISMA AND RECOVERY

One of the special contributions some recovering people bring to the helping process is their zeal for passing recovery on to others. Many might be aptly described as recovery evangelists. Such enthusiasm constitutes a type of personal charisma. People possessing this "healing charisma" are described as self-assured, energetic, powerful, hypnotic, magnetic, devoted, and inspiring.[171] They are practical and realistic, yet they elicit, through their words or deeds, hope for a new life. They offer themselves as living proof that such rebirth is possible.

The movement from addiction to recovery is often marked by extreme ambivalence, and those caught in this abyss often conduct pilot sobriety experiments before becoming fully committed to recovery. During this frequently prolonged process, they may enter treatment, not in search of recovery, but to manage their "habit" (by reducing drug tolerance), escape impending consequences, take a needed respite from the pressures of "the life," and "audition" those providing treatment and recovery support.[172] One of the

---

[169] Weisman, M. (1973). The para-professional in a medical setting. In G. E. Staub & L. N. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 66-77). Springfield, IL: Charles C. Thomas.

[170] Personal communication with Ron Hunsicker, CEO of the National Association of Addiction Treatment Providers, October, 2008.

[171] Almond, R. (1974). *The healing community*. New York: Jason Aronson.

[172] Koester, S., Anderson, K., & Hoffer, L. (1999). Active heroin injectors' perceptions and use of methadone maintenance treatment: Cynical performance or self-prescribed risk reduction.

functions of P-BRS is the use of self and exposure to the recovery community to shift this motivational core from a focus on managing addiction to a focus on initiating and sustaining recovery.

Charisma within P-BRS involves many complex dimensions: personal attractiveness, honesty and candor (a "tell it like it is" style), immediate relief through concrete assistance, and the ability to provide sense-making stories and metaphors. Woodward and McGrath (1988) have set forth several propositions about the role of charisma in addiction recovery. These propositions, amplified by the author, include the following points:

- Exposure to charisma can be an asset and liability in the achievement of long-term addiction recovery.
- People who are physically depleted and emotionally dead from severe, prolonged alcohol and other drug problems may need a charismatic style of helping to successfully initiate recovery. (I am reminded here of Eric Hoffer's[173] observation that the less justified a person feels in claiming value for self, the more ready he or she is to embrace a holy cause and follow a charismatic leader.)
- Those who benefit most from charisma in their recovery initiation efforts include those whose lives are marked by low self-esteem and self-efficacy, high levels of pain (high problem severity, complexity, and consequences), low levels of hope (severely depleted personal and family recovery capital), and prior relationships with charismatic figures.
- The need for charisma diminishes in the transition from recovery initiation to recovery stabilization and maintenance.
- Sustained styles of charismatic helping can actually retard the transition to recovery maintenance and enhanced autonomy and quality of life in recovery.

Several added points are worth noting here. First, recovery status alone does not necessarily ensure charisma, but charisma may be more available to people who are working within a framework of experiential knowledge. Second, charismatic styles of helping may be contraindicated for people with high levels of rationality, high levels of self-autonomy, or aversion to social fellowship. Recovery-based charisma may also produce unintended harm in the prevention and public education context. (See later discussion of problems associated with exposing young non-drug users to charismatic ex-addicts.) Third, the strategic use of charisma and the ability to lower or withhold charisma may be easier for peer helpers in late stages of recovery than for peer helpers who are at an early stage of recovery.

A key area of needed inquiry is the effect of charismatic encouragement by recovery role models on recovery initiation. The potential utility of this intervention rests on six points:

Substance Use and Misuse, 34(14), 2135-2153. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

[173] Hoffer, E. (1951). *The true believer*. New York: Harper & Row.

1) By the time people with severe AOD problems seek help, they have often experienced condemnation and rejection by society, social control agents (principals, police, judges, and probation officers), employers, and a host of non-specialized helpers.
2) Most of these social control agents demonstrate little hope for long-term recovery; addiction is highly visible in their work and community lives, but long-term recovery is often not visible from either position.
3) "It is quite possible that the remarkable lack of success reported in helping the alcoholic is directly related to the fact that the helping figure cannot, or does not, either by words or action, demonstrate confidence and faith in the patient's ability to change."[174]
4) What recovering helpers bring to the encounter with those suffering from addiction is a profound sense of optimism about the prospects of recovery—a hope embodied in their own lives and their connection to a community of recovering individuals and families. Such hope stands as a "living refutation of the argument 'once an addict, always an addict.'"[175]
5) The function of charisma is to incite hope and an extreme commitment; its mantra is "Recovery by any means necessary—under any circumstances."

In 1974, John Wallace proposed a related theory that informs the ability of peer specialists to adapt their personal styles of helping. Wallace outlined four linked propositions: 1) the alcoholic develops an elaborate preferred defense structure (PDS) (denial, minimization, black-white thinking, projection of blame, overcompensation) that supports continued drinking and grandiosity, 2) mechanisms within the PDS that support drinking must be maintained but realigned to support early recovery, 3) helping interventions that prematurely weaken the alcoholic's PDS may inadvertently precipitate relapse, and 4) the PDS that supported active drinking and is reframed to support recovery initiation must eventually be replaced with more mature defense mechanisms that support long-term recovery. The latter stage is marked by increased maturity, humility, self-acceptance, flexibility, and tolerance. Wallace's work suggests that the length and quality of sobriety may be predictive of those peer helpers who can strategically allocate personal inspiration in working with persons at different developmental stages of recovery, but suppress such charisma with those people for whom it would be contraindicated.

The role of P-BRS in leading estranged people back into relationship with mainstream communities is based on the assumption that the individual and the community benefit from such inclusion.

Metaphors of contagion (e.g., epidemic, plague, outbreak) have long been used to describe the rapid social transmission of AOD problems

---

[174] Falkey, D. B. (1964). Comment on Krystal, H. and Moore, R. Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol*, *25*, 568-570.

[175] Kadushin, L. & Kadushin, A. (1969). The ex-addict as a member of the therapeutic team. *Community Mental Health Journal*, *5*(5), 386-393, quote from page 389.

within local communities—particularly during periods of drug panic (Jenkins, 1994).[176] *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.*[177]

Bratter,[178] for example, has argued that the self-awareness, maturity, focused dedication, and service ethic of recovering students make them a valuable asset to college campuses via their value of "responsible concern," their ability to check the self-destructive tendencies of other students, and their frequent assumption of campus leadership roles.[179] Pursuing new educational goals has also been found to enhance success in achieving long-term recovery.[180] Belief in such reciprocal benefit to individual and community is a foundational idea of P-BRSS. This contagious ingredient through which recovery is transmitted from one person to another is "compassion, or as many recovered alcoholics simply put it, *love.*"[181]

Charisma also plays an important role in the evolution and vitality of peer recovery support organizations. While charisma may play a role in the birth of peer recovery support movements, the survival and health of such movements often rests on suppressing charismatic authority in favor of group consensus—a principle well-illustrated in the contrasting histories of Alcoholics Anonymous and Synanon.[182]

---

[176] Jenkins, P. (1994). The ice age: The social construction of a drug panic. *Justice Quarterly*, *11*(1), 7-31.

[177] White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment,* 36, 146-58.

[178] Bratter, T. E. (1994). Bright, angry, recovering students: Their value to colleges. *Journal of College Admissions*, *142*, 23-28.

[179] Bratter, T.E. & Parker, T.H. (1994). Bright, angry, recovering students: Their value to colleges. *The Journal of College Admission, 142*, 23-28.

[180] Rutledge, L. M. (2003). Education is a way out: Narratives of recovering addicts who utilized formal education as a part of their recovery journey. *Dissertation Abstracts International*, *64*(10A), 3567.

[181] Mann, M. (1973). Attitude: Key to successful treatment. In G. E. Staub & L. M. Kent (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas.

[182] Borkman, T. (2006). Sharing experience. Conveying hope: Egalitarian relations as the essential method of Alcoholics Anonymous. *Nonprofit Management & Leadership*, 17(2), 145-161; Janzen, R. (2001). *The rise and fall of Synanon*. Baltimore: The Johns Hopkins University Press.

SPIRITUALITY AND RECOVERY

Profound religious or spiritual experience has often served as a catalyst for addiction recovery. Conversion-like experiences that are sudden, unplanned, positive, and permanent have long constituted a distinct pathway or style of addiction recovery. Experiences of such *quantum change* or *transformational change* are well documented in literature on the psychology of religion,[183] in the professional addictions literature,[184] in recovery biographies,[185] and in the literature of recovery mutual-aid societies.[186] The charisma of many of those providing P-BRS springs from such experiences.

Religious leaders extol the power of religious conversion as a vehicle of recovery, but tend to restrict the legitimacy of conversion experience to their particular faith or denomination frameworks. Non-recovering addiction service professionals and allied health and human service professionals bring widely varying attitudes toward religion and spirituality, but in this author's experience have as a group been highly skeptical of conversion experiences (sacred or secular) as a long-term solution to addiction. One of the distinguishing features of P-BRS and the work of P-BRSS specialists is a profound respect for the role of unseen forces and the power of religious, spiritual, and secular conversion experiences as triggers for recovery initiation. That respect comes from participation in communities of recovery within which the lives of some members have been saved and transformed through such experiences.

P-BRSS specialists drawn from membership in these communities do not need research studies to declare that such a style of recovery is possible. They have witnessed over extended time the fruits of transformative change. P-BRSS rest on the belief that developmental windows of opportunity exist in all of our lives—that profound breakthroughs in relationship to self, others, and/or God can forever cleave a life into the categories of before and after and reveal one's personal destiny. P-BRS and P-BRSS are about more than eliminating

---

[183] Begbie, H. (1909). *Twice-born men: A clinic in regeneration.* New York: Fleming H. Revell. Loder, J. E. (1989). *The transforming moment.* Colorado Springs, CO: Helmers and Howard. Starbuck, E. (1901). *The psychology of religion*. New York: Scribner's.

[184] Miller, W. R. & C'de Baca, J. (2001). *Quantum change*. New York: Guilford. White, W. (2004). Transformational change: A historical review. *IN SESSION: Journal of Clinical Psychology,* 60(5), 461-470.

[185] As samples, see Gough, J. (1870). *Autobiography and personal recollections of John B. Gough.* Springfield, MA: Bill, Nichols & Company. Offord, R. M. (1885). *Jerry McAuley: An apostle to the lost*. Harrisburg, PA: Publishing House of United Evangelical Church. Malcolm X & Haley, A. (1964). *The autobiography of Malcolm X.* New York: Grove.

[186] See Alcoholics Anonymous (1984). *"Pass It On": The story of Bill Wilson and how the AA message reached the world.* New York: Alcoholics Anonymous World Services. "Spiritual Experience," Appendix in *Alcoholics Anonymous* (1976). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism*. New York City: Alcoholics Anonymous World Services, Inc., pp. 569-570.

destructive alcohol and drug use; they are about helping people find meaning and purpose whose lives have been wounded and emptied by such use.

Storytelling and the Power of Mutual Identification

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.

> *They* [reformed men] *understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard's heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform... (*From the *Mercantile Journal*, May 27, 1841)[187]
>
> *We were once as you are: come with us and be cured.* (Bi-Chloride of Gold Club/Keeley League, 1891).[188]
>
> *He gave me information about the subject of alcoholism which was undoubtedly helpful. Of far more importance was the fact that he was the first living human with whom I had ever talked, who knew what he was talking about in regard to alcoholism from actual experience. In other words, he talked my language. He knew all the answers, and certainly not because he had picked them up in his reading.* (Dr. Bob S. referring to his first meeting with Bill W.—co-founders of Alcoholics Anonymous).[189]
>
> *…the ex-addict paraprofessional could speak the client's language since he or she shared the same life experiences and background, would be sensitive to manipulation, and was able to act as a role model for the client, i.e., as someone who had been "in the life" and emerged from it successfully*.[190]
>
> *What the recovered alcoholic counselor can do that no one else can do is to be a role model of successful recovery for a sick patient*.[191]

---

[187] Hawkins, W. (1859). *Life of John H. Hawkins*. Boston: John P. Jewett and Company.
[188] Barclay, G. (1964). The Keeley League. *Journal of the Illinois State Historical Society, 57*, 341-365.
[189] *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (Third edition). (1976). New York City: Alcoholics Anonymous World Services, Inc.
[190] Brown, B. S. (1993). Observations on the recent history of drug user counseling. *The International Journal of the Addictions*, *28*(12), 1243-1255.
[191] Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

By "speaking the same language," backed up with common experience, the [recovering] *counselor is often able to affect the first breakthrough in such patients* [those having problems with authority figures]. *He is then able to lead the patient into realistic relationships with the other members of the team.*[192]

This use of self crosses recovery traditions, whether in the form of *witnessing* or *testifying* within faith-based traditions; the sharing of experience, strength, and hope within spiritual traditions; or the simple exchanging stories and strategies within secular recovery traditions.

The emphasis on reciprocal self-disclosure and mutual identification in P-BRSS is in marked contrast to the debate surrounding self-disclosure in psychotherapy[193] and addiction counseling,[194] where such disclosure has been discouraged except under strict clinical guidelines. In contrast, peer helpers often view self-disclosure of their recovery story as self-reparation, an offering of hope to those still suffering, and an instrument of public education that might counter social stigma and widen the doorways of entry into recovery for others. People in recovery must weigh the benefits of such disclosure to individuals, families, and communities against the risks of such disclosure for themselves and their own family members.[195] Guidelines for self-disclosure are being developed for those recovering from addiction and from mental illness.[196]

The self-disclosure debate reflects a broader difference in the degree of personal involvement in the helping relationship by the peer specialist.

The peer encounter is neither narrowly rule-directed nor reflexive; each participant must think, evaluate various alternative actions, and interpret the other's actions…. Consequently, [peer] *support providers must always evaluate how much to invest emotionally and how much to refrain from investing. They must decide how much they want to be distanced from the recipient by the veil of objectivity and detachment versus how much*

---

[192] Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In B. Kissin & H. Beglieter (Eds.), *The biology of alcoholism, Vol. 5, treatment and rehabilitation of the chronic alcoholic* (pp. 545-565). New York: Plenum Press.

[193] Barrett, M. S. & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, *69*(4), 597-603.

[194] Chapman, C. (2000). Ethical issues in the used of self-disclosure for substance abuse professionals. *The Counselor*, *18*, 18-22. Dickerson, L. (1989). Should recovering professionals self-disclose? *Professional Counselor*, *3*, 47-65. Mallow, A. J. (1998). Self-disclosure: Reconciling psychoanalytic psychotherapy and Alcoholics Anonymous philosophy. *Journal of Substance Abuse Treatment*, *15*(6), 493-498. Roes, N.A. (2004). The rules of self-disclosure. *Counselor*, *5*, 26-28.

[195] Corrigan, P. (2003). Beat the stigma: Come out of the closet. Psychiatric Services, 54(10), 1313.

[196] See http://www.facesandvoicesofrecovery.org/publications/recovery_messaging/index.php. Hyman, I. (2008). Self-disclosure and its impact on individuals who receive mental health services. HHS Pub. No. (SMA) 08-4337. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

> *they want to be emotionally invested through empathy, compassion, and caring. This means that support providers must work at finding a balance between the pitfalls of indifference (i.e., detached, bureaucratic helping) and enmeshment (i.e., biased, overly emotional helping), which involves determining the boundaries of the relationship….*[197]

The peer's degree of personal involvement is a strength and vulnerability of P-BRSS. The distancing maneuvers of treatment professionals are intended to ensure objectivity in assessment and counseling, reduce the risk of exploitation in the helping relationship, and minimize the effects of vicarious traumatizaton (VT)—also known as secondary traumatic stress. VT occurs when helpers lack the defenses necessary to protect themselves against the emotional impact of helpees' stories of victimization, degradation, and/or perpetration. Diagnostic schemes, theoretical models, manual-guided service protocols, therapeutic techniques, ethical codes, and brief service relationships all serve as protective shields for the professional. In the world of peer support, the helper has greater levels of emotional exposure.

For the P-BRSS specialist, protection comes not from intellectualization of the horror to which one may be exposed, or by personal distancing, but through support for the helper and helpee from a larger recovery community. In other words, the emotional intensity of reciprocal self-disclosure and the intimacy produced by such disclosure are diffused within a larger community of mutual support. When peer helpers work in isolation from this support, they may injure themselves through the helping process. Some stories are so horrific that their poisons cannot be emotionally digested by the peer helper. This is why, in recovery communities, members are expected to tell "in a general way what we used to be like, what happened, and what we are like now"[198] and leave the disclosure of the more intimate details in their life stories to fifth steps, religious confession, or psychotherapy.

The use of self-disclosure, mutual identification, and the absence of contempt are such important components of the recovery-focused helping relationship that special strategies have been suggested to help professionals not in recovery achieve these ingredients. In 1940, Howard and Hurdum[199] went so far as to suggest that all professional helpers working with alcoholics should be abstinent, including those with no history of alcohol problems.

> *It is essential that complete abstinence be advised to the patient. Accordingly it is advisable that the therapist himself abstain, lest his acts*

---

[197] Bacharach, S. B. (2000). Boundary management tactics and logics of action: The case of peer-support providers. *Administrative Science Quarterly*, *45*, 704-736, quotation from p. 704.

[198] Alcoholics Anonymous (1939). Alcoholics Anonymous: The story of how more than one hundred men have recovered from alcoholism. New York City: Works Publishing Company.

[199] Howard, C. & Hurdum, H. (1940). Therapeutic problems in the alcoholic psychoses. *Psychiatric Quarterly, 14*(2), 347-359.

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."[200]

Program Profile 11: Storytelling Training (Philadelphia, PA)[201]
Purpose: Storytelling Training is supportive, skills-based training for persons in recovery, to assist them in developing their own recovery stories and to boost their confidence in presenting their stories in public venues. The 4 ½-hour training session is held once a month.
Service Elements: 1) Introduction to recovery-focused systems transformation process; 2) story presentation guidelines and tips for different audiences; 3) storytelling practice with support and feedback; 4) discussion of story presentation opportunities.
Service Volume/Status: As of November, 2008, 31 Storytelling Training sessions have been conducted, involving 370 participants; four Family Storytelling Training sessions have been conducted for 100 participants.
Service Outcomes: 1) Graduates of Storytelling Training have been invited as presenters in various recovery-oriented trainings, conferences, and other community education events; 2) Storytelling Training has served as portal of entry to other training and service opportunities; 3) some graduates have gone on to obtain employment in the behavioral health field.
Service Lessons: 1) Storytelling Training has had unintended positive consequences for the participants and the system, including dramatic levels of personal empowerment and personal networking, and enhanced involvement and effectiveness of graduates in other systems-transformation activities; 2) the training is an exceptional tool for building relationships among people in recovery.
For More Information: Contact Seble Menkir at seble.menkir@phila.gov or 215-685-5498.

STIGMA AND THE DYNAMICS OF HELP-SEEKING

Peer recovery support is a potential antidote to the barriers people encounter in seeking professional help for severe AOD problems.

The only professional who will stop for a drunk on the street is a policeman.[202]

---

[200] Howard, C. & Hurdum, H. (1940). Therapeutic problems in the alcoholic psychoses. *Psychiatric Quarterly, 14*(2), 347-359.

[201] Personal communications with Ellen Faynberg and Joan King, November 2008.

[202] Staub, G. & Kent, L. (1973). Thoughts to ourselves. In G. E. Staub & L. M. Kent. (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas.

I wonder if you or other helping professionals remember what it is like to ask for help…with nothing more than your own personhood as the reason for anyone's lifting even a little finger to provide assistance…Could it be that in order to be able to give help you should first learn how to receive help?[203]

Help receiving is a difficult role. It tends to underline one's inadequacy…The new paradigm calls for the restructuring, redistribution, and expansion of helping behavior by those who ordinarily function as consumers of help.[204]

If there is a single condition that has spawned the historical involvement of recovering people in service work, it is the contempt with which society and mainstream service professionals have viewed those suffering from alcohol and other drug addiction.

Contempt, often mutual, is an enduring and troubling theme in the historical relationship between helping professionals and addicts. The addiction treatment industry as a specialized field grew out of the contempt in which other helping systems regarded alcoholics and addicts. For generations, physicians, nurses, social workers, psychologists, welfare workers, and other service professionals barely masked their contempt for the alcoholic and addict. Beneath the veneer of professional discourse about addicts during the past century lies a pervasive undertone: Most professionals simply do not like alcoholics and addicts.[205]

By altering these conditions, peer-based supports provide adjuncts or alternatives to professional assistance that can expand help-seeking, enhance the quality of the helping experience, and improve the stewardship of scarce community resources.[206]

If there is an inner core to the experience of addiction, it is a core of shame and the anguish and despair that flow from it.[207] That shame has many sources—the stain of experiencing oneself as unworthy and unlovable, the sins committed in the worship of one's sacramental drug, and the pariah status of anyone forced to embrace the caricatured label of alcoholic or addict. Those so condemned can catch the briefest condemnation in the eyes, the faintest tone of judgment and condescension in the voice, and the slightest hesitation to reach for an extended hand. Peers understand such shame. Their eyes dance with

---

[203] Morgan, C. A. (1987). I, the client. In G. Gandy (Ed.), *Rehabilitation counseling and services: Profession and process* (pp. 234-243). Springfield, IL: Charles C. Thomas.

[204] Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry*, *18*(2), 221-230.

[205] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[206] Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry*, *18*(2), 221-230.

[207] Personal communication with Dr. Garrett O'Connor, January 2009.

understanding, their voices offer a balm of profound empathy, and their touch is a welcoming embrace of inclusion and hope for redemption.

What recovering people have long brought to their service work is a relationship based on moral equality, respect, emotional authenticity, and a "kinship of common suffering."[208]

> *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.*[209]

> *…we use the Socratic Method—we don't teach by lecturing, we teach by asking questions that help them* [those reached through outreach] *answer the questions themselves….Most addicts like me have had bad experiences with authority figures: doctors, police, teachers, parents. We tend to not trust people in general. So we try to let group members see that we'll give them straight talk, aren't interested in judging them, and that it wasn't so long ago that we peer educators were walking in their shoes.*[210]

> *I like for you to extend your hand across to me—not down to me. In the warmth of your clasp I want to sense you saying, "As one human being to another, we are in this fight together. We are joined in problems that in one form or another continue to pester me, too." When this happens and you have really come alive as a person, then I'll be in a lot better mood to listen to what you have to offer.*[211]

Professionals who have not been humbled by their own moments of reckoning can offer many things, but the one thing they can never extend to the suffering addict is the word "we." The experience of "we" is the healing balm offered by those who may lack qualifications of education and professional training.

The task of the professional addictions counselor is to recognize any existing feelings of judgment, aversion—even repulsion—as components of a process of countertransference. Such feelings require expression within the clinical supervision process, to reduce their presence within and impact upon the service relationship. Similarly, not all peers share the same level of empathy with and acceptance of those they serve. For example, the pecking order within American cultures of addiction (and, in fact, within any stigmatized group) can

---

[208] Alcoholics Anonymous (1957). *Alcoholics Anonymous comes of age*. New York: A.A. World Services, Inc.

[209] A Member of the Society. (1842). *The foundation, progress and principles of the Washingtonian Temperance Society of Baltimore, and the influence it has had on the temperance movements in the United States*. Baltimore: John D. Toy.

[210] Galindo, L., Maginnis, T., Wallace, G., Hansen, A., & Sylvestre, D. (2007). Education by peers is the key to success. *International Journal of Drug Policy*, *18*(5), 411-416.

[211] Morgan, C. A. (1987). I, the client. In G. Gandy (Ed.), *Rehabilitation counseling and services: Profession and process* (pp. 234-243). Springfield, IL: Charles C. Thomas.

generate negative emotions that are as injurious as those elicited by some professionals. Recovering peers drawn from these cultures can unconsciously bring these past attitudes into their service relationships, e.g., the historical superiority of the "righteous dope fiend" over the "gutter hype," the "alcoholic" over the "wino," and the "snowbird" over the "crack whore." Such elitism "among the damned" was evident in early recovery support societies that wanted only "drunkards of good repute" to be members of their societies.[212] Peers, like professionals at their best, must find ways to transcend sources of bias that corrupt the helping process. The challenge for the peer is to strive for the utter openness and acceptance that flows from the "we" position and to recognize and support people through, rather than rescuing them from, the authentic suffering that is so often critical to recovery.[213]

The transition from a professional to a peer orientation—from hierarchical to reciprocal relationships—is well illustrated in the shift within recovery schools (recovery programs established within secondary and collegiate educational institutions) from the use of professionally directed therapy groups to "talking circles."

> *Participants sit in a circle, and a keeper or facilitator (either staff or student) opens the circle, welcomes everyone, and passes a talking piece. The person who has the talking piece gets to speak, hold it in silence, or pass it on. Everyone else gets to listen...Everyone is heard, everyone listens….In the circle, the youth feel they can speak truthfully because all are treated equally, people can pass without serious consequences, and confrontation is replaced by deeper listening. It is a safe place*.[214]

The peer recovery support relationship is contingent on escaping the asymmetry of power that exists in the professional helping relationship. Historically, P-BRS models reject language describing peer-helping that injects such asymmetry—words like *treatment, clinical, diagnosis, counseling, therapy, therapeutic*. The language of P-BRS is demystified and egalitarian: *helping, supporting, guiding*, and *assisting*.[215] An ethnographer comparing the milieu of a P-BRSS organization and a professional treatment organization would be struck by their differences in language, with the former describing engagement using words rarely heard in clinical settings.

> *It takes time to engage people who've been beaten down for so long. They have to check us out to see if we're one of those places just in it for the money. They have to find out if there's something to us or if this is*

---

[212] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[213] Personal communication with Dr. Garrett O'Connor, January 2009.

[214] Riestenberg, N. (2007). The restorative recovery school: Countering chemical dependency. *Reclaiming Children and Youth*, *16*(2), 21-23.

[215] Hiltner, S. (1964). Comment on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol*, *25*, 354-357.

some kind of hustle. Trust and understanding is what hooks them and keeps the recovery process moving forward. And this is not about forms or techniques; it's about that eye-to-eye and heart-to-heart connection. It's about using honesty and love to get inside somebody. My stance is, "you can bullshit me, but I will know you're bullshitting and still love you. And I'll hang in with you 'til you decide to get real." I show them that a different way of living is possible. (Samuel Morales, Outreach Specialist, New Pathways Project, Philadelphia, PA)

Program Profile 12: Taking Recovery to the Streets (Philadelphia, PA)[216]
Purpose: 1) To test the feasibility of training people in recovery to provide recovery education to people seeking treatment and recovery support services, 2) to provide service opportunities for people in recovery, 3) to engender hope and basic knowledge about recovery in service recipients by using recovery role models and their experiential wisdom. (Program started in 2007)
Service Elements: 1) Training and certification program for recovery ambassadors, 2) presentations at treatment and rehabilitation programs, shelters/safe havens/cafes and local conferences.
Service Outcomes: 1) 21 people in recovery have been trained and certified, 2) 12 behavioral health organizations have sponsored presentations to their clients, 3) peer support relationships have developed between presenters and participants, 4) stipends paid for the presentations provide supplemental income for individuals/families in recovery, 5) four of the presenters have become certified peer specialists and are now working at a behavioral health organization.
Service Lessons: 1) The central message of systems transformation—the hope for long-term recovery—can be best conveyed by people in long-term recovery, and the recovery message is being delivered by people in recovery directly to people seeking recovery; 2) there is a need to identify and train bilingual people in recovery as ambassadors; 3) recovery ambassadors might be a major system-wide resource and a resource for recovery-focused education of the larger community.
For More Information: Contact Tom O'Hara at Tom.OHara@phila.gov or 215-410-0445

SHARING RECOVERY CAPITAL

Recovery capital, a concept developed by Granfield and Cloud, is the sum total of internal and external resources that can be mobilized to initiate and sustain long-term addiction recovery.[217] The concept is related to the idea of

[216] Tom O'Hara, Personal Communication December, 2008.

[217] Granfield, R. & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press; Cloud, W. & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use and Misuse*, 43(12), 1971-1986.

"social margin," defined by Wiseman[218] as "the leeway a given individual has in making errors…without suffering serious penalties such as being fired, denied credit, or losing friends or family." Recovery capital and social margin include credits earned in relationships with others that can be cashed in for support during the effort to recover from addiction. Individuals with high problem severity/complexity/chronicity and low recovery capital face significant obstacles to their recovery, due to their depleted internal assets and exhausted social credit.[219] Such people are aptly described as having "burned their bridges."

A key activity of the P-BRSS specialist is to "lend" those seeking recovery some of the peer's own recovery capital and social credit until such time as the recovery seeker can regenerate his/her own personal and social assets. This capital/credit can span traits and attitudes (hope, determination, and confidence), resources (clothing, food, money, and shelter), and relationships (social connections with conventional society and spiritual connections to sources of power outside the self).[220] *Giving* recovery capital would be a form of charity exchange involving roles of authority and submission; *sharing* recovery capital is a transaction between equals through which new personal assets are created for both parties. Debts incurred by the person being helped can be repaid later by returning such support to the helper or passing it on to others.

THE HELPER THERAPY PRINCIPLE

The peer helping process is reciprocally beneficial: the helper and helpee draw value from helping exchanges. The helper therapy principle originally set forth by Riessman[221] states simply that, in the course of helping others, one's own problems diminish. What one receives as a recipient of P-BRSS is not charity, but an exchange from which both parties benefit. Equality of power and reciprocity of benefits are essential ingredients of P-BRS. What is needed—and in fact has long existed in recovery mutual-aid societies—is a cooperative learning environment in which helping and being helped are reciprocal and widely distributed.[222]

> *The …strategy ought to be to devise ways of creating more helpers! Or, to be more exact, to find ways to transform recipients of help into dispensers of help, thus reversing their roles, and to structure the*

---

[218] Wiseman, J.P. (1979). *Stations of the lost: The treatment of skid row alcoholics*. Chicago: University of Chicago Press.

[219] White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

[220] Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, *16*(3), 321-337. Fagan, R. & Mauss, A. (1986). Social margin and social reentry: An evaluation of a rehabilitation program for skid row alcoholics. *Journal of Studies on Alcohol, 47*, 413-425.

[221] Riessman, F. (1965). The "helper" therapy principle. *Social Work*, *April*, 27-32.

[222] Riessman, F. (1990). Restructuring help: A human service paradigm for the 1990s. *American Journal of Community Psychiatry*, *18*(2), 221-230.

situation so that recipients of help will be placed in roles requiring the giving of assistance.[223]

People can find capital in their troubles and use them to provide access to leadership, livelihood in the clientele organizations or entrée into the profession that services the group.[224]

Alcoholics Anonymous has capitalized on the helper principle through its practice of sponsorship. Similarly, new recovery community centers are blurring the line between helper and helpee by encouraging all participants to give and receive support from one another, on the assumption that everyone brings needs and assets. Acts of helping afford opportunities for 1) introspection and insight—seeing oneself freshly in the experience of the other, 2) extracting important life lessons via the self-disclosure process, 3) resolving one's own ambivalence by persuading others, 4) enhanced physical and emotional health, 5) achieving the social status inherent in the helper role, and 6) envisioning the potential for new roles and opportunities.[225] The positive effects of helping on recovery are confirmed in multiple studies (see chapter four) and even exert positive effects on active drug users.[226]

INDIVIDUAL, COMMUNITY, CULTURE

In culturally besieged communities, hope for individuals and families must be couched in a broader vision of hope for a people; in all communities, understanding the ecology of recovery is key to the design of effective P-BRSS. P-BRSS, at their best, supplement intrapersonal interventions with efforts to anchor recovery within each client's natural environment or, failing that, create an alternative environment in which recovery is possible.

In the Red Road to Wellbriety, 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.[227]

We must begin to create naturally occurring, healing environments that provide some of the corrective experiences that are vital for recovery.[228]

---

[223] Riessman, F. (1965). The "helper" therapy principle. *Social Work*, *April*, 27-32.

[224] Gusfield, J. (1982). Deviance in the welfare state: The alcoholism profession and the entitlements of stigma. *Research in Social Problems and Public Policy, 2*, 1-20.

[225] Riessman, F. (1965). The "helper" therapy principle. *Social Work*, *April*, 27-32; Thoits, P. A. & Hewitt, L. N. (2001). Volunteer work and well being. *Journal of Health and Social Behavior*, *42*, 115-131. Zemore, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, *100*(4), 447-450.

[226] Latkin, C.A. (1998). Outreach in natural settings: The use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Reports*, 114, Supplement 1, 151-159.

[227] White Bison. (2002). *The red road to wellbriety.* Colorado Springs, CO: White Bison, Inc.

[228] Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies.* New York: Routledge.

Organizations that promise to rehabilitate or cure people with AOD problems and return them to the family/community often end up further isolating those individuals from the family/community. The greater the physical, psychological, and cultural distance between a helping organization and the natural environment of the person being helped, the greater will be the difficulty transferring learning from the former to the latter.[229] P-BRSS provide a vehicle to close this gap by forming a bridge between professional and natural environments and by developing and mobilizing recovery supports within each person's natural environment. P-BRSS, rather than focusing solely on intrapersonal healing, focus on guiding marginalized individuals and families back into the lives of their local communities.[230]

P-BRS enhances the effectiveness of professional helping agencies, in part by building bridges of community involvement for those who have lived as cultural outsiders. Achieving that feat requires sustained involvement of the P-BRSS specialist in networks of community relationships—a style of involvement that can be threatened by professionalism of the P-BRSS role. The following view of the administrator of a street outreach program utilizing "paraprofessional ex-addicts" exemplifies this potential:

> *…any overserious assumption of middle-class roles by the workers could seriously jeopardize their effectiveness and would undercut the fundamental rationale of an effort employing former addicts, knowledgeable in the ways of addiction, to help practicing addicts*.[231]

Kaufman, in his study of the use of ex-addicts in prisons, similarly notes the tension between what the ex-addict helper needs for his own stability and recovery (e.g., to break contact with drug-copping neighborhoods) and what is needed as a helper to others (e.g., sustained sensitivity to the culture and folkways of those neighborhoods).[232]

Ideally, P-BRSS flow from the cultural and geographic communities being served. The individuals providing the services are vetted by the community. The services themselves are designed by and for the community and tap indigenous recovery support resources within the community. Also, the community leaders and stakeholders have a role in valuing as well as evaluating the services. Where justifying claims of "evidence-based" practices rely on external authority,

---

[229] White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment,* 36, 146-58.

[230] McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books. Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, *49*(4), 550-561.

[231] Bullington, B., Munns, J., & Geis, G. (1969). Purchase of conformity, ex-narcotic addicts among the bourgeoisie. *Social Problems, 16*(4), 456-63.

[232] Kaufamn, E. (1978). The use of ex-addicts and other paraprofessionals as mental health workers in prison. *Diseases of the Nervous System*, 37(12), 679-682.

"culturally vetted" services rely on a community stamp of approval via the community's indigenous leaders and community storytelling.[233]

Addiction can be a manifestation of estrangement from the community or generate such estrangement over time. Peer recovery support provides a framework for reconciliation in the person-community relationship. Folgheraiter and Pasini refer to this process as "civic recovery" and refer mutual-aid groups as a "gym for active citizenship."[234] P-BRS provides an incubation chamber in which the person-community relationship can be repaired and reconstructed. The essential ingredients in this process are self-inventory, confession of harm to community, acts of restitution, and acts of service.

CULTURES OF ADDICTION AND RECOVERY

Addiction and recovery, and the transition from the former to the latter, can be as much a physical and cultural journey as an intrapersonal journey.[235] There are elaborate cultures of addiction and cultures of recovery—mirrored in their organization by age, gender, ethnicity, social class, sexual orientation, drug choice, and neighborhood—that respectively support one's addiction or recovery status. Individuals can be as dependent upon the culture of addiction—its language, values, roles, rituals, and relationships—as they are on the drugs that form the centerpiece of that culture. Individuals deeply enmeshed in a culture of addiction may need to become equally enmeshed in a culture of recovery during recovery initiation, and may need a guide to help them make the journey from one culture to the other.[236] The P-BRSS specialist, who is knowledgeable but not defensive about local communities of recovery, can offer such guidance.[237]

> *Junk is not just a habit. It is a way of life. When you give up junk, you give up a way of life*.[238]

---

[233] White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, 26(3), 365-395.

[234] Folgheraiter, F. & Pasini, A. (2009). Self-help groups and social capital: New directions in welfare policies. *Social Work Education*, 28(3), 253-267.

[235] Agar, M. (1977). *Ripping and running: A formal ethnography of urban heroin addicts.* New York: Seminar Press, Inc. Spradley, J. (1970). *You owe yourself a drunk : An ethnography of urban nomads.* Boston: Little, Brown & Company. Waldorf, D. (1973). *Careers in dope.* Englewood Cliffs, NJ: Prentice-Hall, Inc. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

[236] White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

[237] Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In B. Kissin & H. Beglieter (Eds.), *The biology of alcoholism, Vol. 5, treatment and rehabilitation of the chronic alcoholic* (pp. 545-565). New York: Plenum Press. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

[238] Burroughs, W. (1953). *Junkie: Confessions of an unredeemed drug addict*. New York: Ace Books.

Because of the P-BRSS specialist's intimate knowledge of the cultures of addiction and recovery, as well as of the addiction/recovery experience, he or she is in an ideal position to serve as a bridge—an interpreter, liaison, and advocate—in the relationship between the professionally trained therapist and individuals entering addiction treatment. P-BRSS specialists approach those they serve from the position of cultural insider: one knowledgeable of the culture of addiction and, more important, one who can serve as a guide through the pathways of egress from this culture, an egress that involves the translation of knowledge and skills from one world to the other.

Preventing Harm in the Name of Help

Within the history of addiction treatment and recovery there is a long history of harm inflicted in the name of help.[239] P-BRSS are not immune from such potential for harm. Safeguards must be taken to reduce these risks.[240]

The first step in such protection involves the selection of peer specialists, whether they operate in paid or volunteer roles. Advocates of P-BRSS do not suggest that ALL persons in recovery are by their recovery status qualified to help those addicted to alcohol and other drugs. Some individuals in recovery are too damaged by their addiction or are characterologically unsuited (e.g., impatient, dogmatic, unsympathetic, intolerant, critical, manipulative, exploitive) for such a role.[241] Others are simply too immature and self-involved to function as peer helpers.

> *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 is scarcely an ideal candidate* [for an alcoholism counselor].[242]

Since the "paraprofessional" days of addiction counseling, concerns have been raised about the potential harm that might come from peer models of helping. Even early advocates of employing ex-addicts as counselors cautioned about problems related to nepotism, financial malfeasance, sexual exploitation of

---

[239] White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals, *Counselor*, 9(6), 10-17.

[240] For findings on inadvertent harm from peer-based prevention models, see Valente, T.W., Ritt-Olson, A., Stacy, A., Unger, J.B., Okamoto, J. & Sussman, S. (2007). Peer acceleration: effects of a social network tailored substance abuse prevention program among high-risk adolescents. *Addiction*, 102(11), 1804-15.

[241] Root, L. (1973). In-service training of the para-professional in the field of alcoholism. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 40-57). Springfield, IL: Charles C. Thomas Publisher.

[242] Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press.

clients, and other ethical problems that might arise when ex-addicts were placed in positions of authority without adequate supervision.[243]

These concerns may be magnified in peer-support models for adolescents. Same-aged peers may be looked upon with suspicion by parents and/or treatment staff, or regarded as not mature enough or as not having sufficient recovery time, and older peers may be looked upon with suspicion out of fears that they might take advantage of younger adolescents seeking recovery.[244] Concerns have also been raised about ex-addicts employed in schools as agents of drug prevention, [245] particularly the concern that the charismatic young ex-addict might inadvertently "turn the adolescent non-drug user on to drugs through his attractive role modeling."[246]

In determining the potential of the P-BRSS specialist for help or harm, it is important that such determinations be made based on a judgment of each individual rather than on sweeping stereotypes, whether those stereotypes are of a positive or negative nature. As Dr. Donald Louria noted in 1973:

> *…whether in rehabilitation, community services, or education, the ex-addict's role must be determined on an individual basis. Some have the capacity to do a very good job and their drug experiences, incorporated into their formal roles, augments that capacity. Others are mediocre and still others are poor and should be encouraged to focus on job opportunities outside the arena of drug abuse.*[247]

Efforts to prevent inadvertent harm within P-BRSS include careful screening and selection of staff and volunteers and orientation, training, and supervision of P-BRSS that emphasize practicing within and only within the boundaries of one's education, training, experience, and role. Some recovery community organizations have clarified the roles of recovery coach, sponsor, and addiction counselor[248] and articulated core recovery community values (and ethical guidelines) to guide the actions of P-BRSS specialists.[249]

---

[243] Siassi, I., Angle, B.P., & Alston, D.C. (1977). Who should be counselors in methadone maintenance programs: Ex-addicts or nonaddicts? *Community Mental Health Journal*, *13*(2), 125-132. Weppner, R. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 103-105.

[244] Lora Passetti, Personal communication, December, 2008.

[245] Kline, J.A. & Wilson, W.M. (1972). Ex-addicts in drug abuse prevention education. *Drug Forum*, *1*(4), 357-366.

[246] Gerber, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 105-106.

[247] Louria, D. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 106-109.

[248] White, W. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703.

[249] Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumers-providers: Barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199-213. 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.

Another aspect of harm in the name of help involves potential injury to individuals in recovery who work in volunteer or paid recovery support roles. Such injury can come from:

- The emotional strain accompanying efforts to help individuals with severe and complex problems;
- Role ambiguity, role conflict, role overload, and inadequate role feedback experienced in the role of recovery coach; [250] and
- Role safety concerns and exposure to drug-using cues for those working as outreach workers.[251]

All of these conditions can heighten vulnerability to relapse among recovering people working in P-BRSS roles. (See chapter six for studies on relapse rates.) Such vulnerability can be reduced via length-of-recovery requirements; care in screening and selection; and effective orientation, training, and supervision.

STEWARDSHIP OF COMMUNITY RESOURCES

P-BRSS constitute a delivery device for long-term recovery support that can enhance recovery outcomes at costs far lower than those that would be necessary to provide sustained professional care. As the financial resources allocated to addiction treatment erode, P-BRSS are being considered as cost-effective alternatives to professional treatment for people with low-to-moderate problem severity and as ways of supporting the recovery of people with high problem severity and complexity who have received professional treatment. Put simply, P-BRSS are cost effective and contribute to better recovery outcomes. Dr. Tom Kirk, Commissioner of the Connecticut Department of Mental Health and Addiction Services, recently affirmed this rationale.

> *When we examined our service utilization data, we found that 20 percent of our behavioral health clients were consuming approximately 80 percent of our resources by repeatedly recycling through our most acute and expensive levels of care. Our investment in recovery support services was an attempt to generate better recovery outcomes. We are finding ways to use intensive case management and peer support to reduce excessive service utilization and increase recovery outcomes for this group of clients, and to divert the dollars we are saving through this effort to invest in recovery support service programs* (Thomas Kirk, Personal communication, September, 25, 2008).

---

[250] White, W. (1979). *Relapse as a phenomenon of staff burnout in recovering substance abusers*. Rockville, MD: HCS, Inc.

[251] Wiebel, W.W., Biernacki, P. Mulia, N. & Levin, L. (1993). Outreach to IDUs not in treatment. In B. Brown and G. Meschner (Eds.), *Handbook on Risk of AIDS: Injection drug users and sexual partners*. Westport, CT: Greenwood Press. Woods, M.G., Shorty, V., Jones, A., Ingram, P.W., Douglass, B.D. & Dennis, M. (ND). Outreach workers: Theory and a practical application. Unpublished manuscript.

To recovery advocates, treating addiction with serial episodes of expensive acute stabilization without sustained recovery support services is like treating a bacterial infection with only half of the needed antibiotics. The symptoms may disappear temporarily, but the condition is likely to return in a more virulent and intractable form.

This monograph has been written in the midst of a collapsing American housing market, plummeting stock values, declining city and state tax revenues, and much talk about a sustained economic recession, all ushering in a new era of fiscal austerity. In these conditions, professional treatment resources are shrinking, and some policymakers and administrators are suggesting that the movement toward peer-based support services and the broader transformation to a recovery focus should be slowed or postponed until the economy improves.

Recovery advocates believe that these times offer a real opportunity to transform the way in which help is delivered to people seeking recovery. Peer-based recovery support services complement existing professional treatment, increasing its effectiveness and providing more opportunities for sustained recovery. These supports, provided through service organizations, are complemented by recovery mutual-aid societies. It is interesting to note that the economic condition we find ourselves in today is similar to that which saw the rise of Alcoholics Anonymous during the Depression.

Pathways to recovery, including professional treatment, must be built on a foundation of indigenous recovery support that is not vulnerable to the vagaries of policy shifts and economic cycles. How many local addiction treatment programs have disappeared during the decades in which peer-based mutual-aid societies like AA have maintained continuous existence and accessibility?

THE THREATS OF ANTI-PROFESSIONALISM AND PROFESSIONALISM

As a recovery orientation evolves, including the expanded use of peer-based recovery support services, there are two threats to this important movement. The first risk lies in the propensity for anti-professionalism, "incestuous closure," and organizational implosion.[252] While intertwined with one another and integral to recovery success, P-BRSS and professionally directed addiction treatment services are grounded in fundamentally different ways of knowing. Both face similar threats as they evolve. The first is the danger of casting their way of knowing and what has been learned through that method as the *whole* truth.

> *In closed systems, organizational beliefs are transformed into a holy cause. Ideologies are not just defined as true; they are defined as THE Truth—one that is whole and fully evolved. Any proposed alteration is*

[252] Janzen, R. (2001). *The rise and fall of Synanon*. Baltimore: The Johns Hopkins University Press. Riessman, F. (1965). The "helper" therapy principle. *Social Work*, *April*, 27-32. White, W. (1997). *The incestuous workplace: Stress and distress in the organizational family*. Center City, MN: Hazelden.

seen as a violation of its perfection….Philosophy becomes gospel, gospel become dogma, and dogma is codified in doctrine.[253]

The history of addiction treatment and recovery is strewn with the carcasses of professional and peer-based organizations that saw their own ideas and ways of knowing as the only source of truth.

A second danger is that the forces of professionalization, bureaucratization, and commercialization will usurp P-BRSS —displacing experiential knowledge with theoretical knowledge and concerns about organizational management and finance. If there is a wholesale shift in focus from people to paper, profit, and professional status, the conditions will be set to threaten the very hope and promise that this new recovery orientation holds out.[254] AA's co-founders each faced the temptation of professionalism, but eschewed professionalizing their AA service work. After much deliberation, Bill Wilson turned down an offer to work as a lay alcoholism therapist at Charles Towns Hospital,[255] and Dr. Robert Smith refused to charge fees for the more than 5,000 alcoholic men and women he treated medically.[256] However, when these colonizing forces succeed, conditions are set for the rise of new movements that re-extol the value of experiential knowledge—as is now happening through the growing interest in P-BRSS.

This does not suggest that professional or recovery community organizations should not seek financial resources to pursue their respective missions. But it does suggest the importance of filtering all issues of finance through the question of whether pursuing a particular resource will enhance the mission of increasing individual, family, and community recovery capital or be a diversion from this mission.

Financial considerations can also have a negative impact on relationships with clients within the professional paradigm. Along with a rigid adherence to this paradigm, the constraints imposed by managed care and financial scarcity can lead to loss of mutual vulnerability, inequalities in power, preoccupation with papers and procedures, and distracting fixations on time spent in sessions (limited doses, days, etc.) and money. The milieu of modern addiction treatment has cooled dramatically through its maturation. P-BRSS constitute an effort to re-inject personal passion and personal involvement back into the recovery catalyst process, and their effects on support relationships have often been highly positive.

Concerns about the professionalization of P-BRSS go far beyond styles of knowing. At a practical level, professionalism in any field involves pushing

---

[253] White, W. (1997). The incestuous workplace: Stress and distress in the organizational family. Center City, MN: Hazelden.

[254] Blum, T. & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors. *Journal of Health and Social Behavior*, *26*(4), 365-378. White, W. (2006a). The voice of history: Sponsorship and peer-based recovery support services. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recover*y, *Winter Issue*, 7-8.

[255] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[256] Was Dr. Bob the first two-hatter? (1975). *AA Grapevine, 31*(8), 14-15.

issues congruent with the financial interests and social status of the profession and protecting one's declared turf from encroachment by other professions and cultural institutions.[257] Successful efforts at professionalization usually occur in tandem with the rise of new social institutions. Such linked events can fundamentally redefine the recovery support relationship and shift the focus of that relationship from the needs of the person to the needs of the service profession and the service institution. Those peer-based efforts that have survived over time have sustained core values and principles, such as AA's Twelve Traditions, that have helped members and the organization as a whole avoid the temptations of professional status and financial profit.

To sustain their non-professional status, recovery community organizations providing peer-based recovery support services must find a way to transcend what Robert Michels[258] referred to as the "iron law of oligarchy"—the tendency of organizations to become less democratic, and for organizational relationships to become less egalitarian, as organizations grow in size and complexity. In Michels' view, the emerging need for efficiency, rapid decision-making, task delegation, and role specialization inevitably breeds bureaucratization, centralization of power, and relationships based on authority.

A conscious and sustained effort to avoid these tendencies and their effects on service relationships is a distinctive quality of organizations whose missions include the delivery of P-BRSS.[259] The move to professionalize P-BRSS, driven in part by the desire for reimbursement, is being undertaken with the noblest of intentions, to improve opportunities for sustained recovery. However, if care is not taken, the essence of what distinguishes peer support from professionally directed treatment services might be destroyed. This corruption might occur within any organizations—from treatment programs to recovery community organizations—that offer P-BRSS.

There is a process through which indigenous non-professionals can lose their effectiveness by over-identifying with the professional organization that has hired them and the organization's professional values.

> *In overidentifying with the agency in this way, the nonprofessional worker underidentifies with the community. He may begin to feel superior to his less fortunate fellows…This type of reaction militates against effectiveness of the nonprofessional as a communication link….Care must be taken in both selection and training to expose, and clearly oppose, this tendency*.[260]

---

[257] Van Wormer, K. (1986). The sociology of alcoholism counseling: A social worker's perspective. *Journal of Sociology and Social Welfare*, *13*(3), 643-656.

[258] Michels, R. (1915). *Political parties: A sociological study of the oligarchical tendencies of modern democracy* (E. Paul & C. Paul, Trans.). New York: The Free Press.

[259] The fellowship of Alcoholics Anonymous illustrates how this can be done via the decentralization and rotation of leadership and the codification of organizational values (e.g., Twelve Traditions) about the management of power, money, property, professional status, and public esteem.

[260] Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

Care might well be taken that the training…[of recovering addicts to become counselors] does not have as its objective the manufacture of junior therapists such that the counselor is led to ape the behaviors of the "professional" in uncovering and understanding client problems rather than in providing client guidance and support for undertaking new behaviors. The temptation may be large for both the counselor and trainer to make the counselor over in a traditional therapist image. In this transition, he may begin to ignore, if not downgrade, some of the advantages he brings to the counseling situation by virtue of his community and life experiences.[261]

The reverse of this process can also occur when professional models of addiction treatment are abandoned for the experience-based models of care characterized by anti-intellectualism, anti-professionalism, and a disregard for mainstream regulatory and funding structures.

The loss of either way of knowing—experiential knowledge or professional knowledge—constitutes a loss. These different ways of knowing can be highly complementary and offer valued and variable help that responds to the unique needs of individuals and families at different points in their addiction and recovery careers. The tension between these ways of knowing may also be a source of continued organizational renewal that helps professional and peer-based organizations escape Michels' iron law of oligarchy.

PRIMACY OF PERSONAL RECOVERY AND IMPORTANCE OF SELF-CARE

All peer-based recovery support services rest on the primacy of personal recovery. There are positively evaluated projects that have engaged peer leaders within illicit drug cultures to serve as peer helpers to reduce HIV transmission among injection drug users,[262] but studies have shown that outreach workers in recovery have greater credibility with active drug users than do those who are still using.[263] AA co-founder Bill Wilson stated the operative principle here: "…you cannot transmit something you haven't got."[264]

One of the profoundly important lessons within the history of P-BRSS is that offering recovery support to others is not <u>in itself</u> a program of personal

---

[261] Brown, B. S. & Thompson, R. F. (1975). The effectiveness of formerly addicted and nonaddicted counselors on client functioning. *Drug Forum*, *5*(2), 123-129.

[262] Latkin, C.A. (1998). Outreach in natural settings: The use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Reports*, 114, Supplement 1, p. 151-159).

[263] Mitchell, S.G., Peterson, J.A. & Latkin, C.A. (2006). The impact of drug use on perceptions of credibility in indigenous outreach workers. *Qualitative Health Research*, 16(8), 1108-1119.

[264] *Alcoholics Anonymous: The story of how more than one hundred men have recovered from alcoholism*. (1939). New York: Works Publishing Company, p. 178.

recovery.[265] That lesson surfaces repeatedly within the early history of addiction treatment and recovery, and relapse has continued to be a concern within the modern history of addiction counseling and P-BRSS.[266] Alcohol- or drug-related impairment continues to be among the top reasons for ethics complaints filed against addiction counselors.[267] In response to this history, self-care is an important theme within the contemporary culture of P-BRSS—perhaps more so than within mainstream helping professions. This primacy of recovery must be sustained in the face of the P-BRSS specialist's potential estrangement from his or her professional colleagues (via being devalued, disrespected, and underpaid) and his or her own recovery community (via criticism for "making money off the Program").[268] Such marginalization can pose threats to one's sobriety, well being, and sanity.

The primacy of recovery for P-BRSS specialists goes beyond just maintaining abstinence. It encompasses the personal qualities and style of living that make long-term recovery possible, meaningful, and attractive to others. Humility and harmony are frequently cited by P-BRSS specialists as aspirational values. To sustain humility, we must avoid "Stratton's Disease" (the grandiose delusion that we understand addiction and recovery better than anyone else)[269] and falling in love with the image of ourselves as helpers—stances that transmit an air of superiority and benevolent condescension that repels the very people we deem to help. To sustain harmony and balance, we must regularly monitor and adjust the time and emotional resources that we allocate to self, family, community, and those seeking recovery.

---

[265] White, W. (2006a). The voice of history: Sponsorship and peer-based recovery support services. *Recovery Rising: Quarterly Journal of The Faces and Voices of Recovery*, *Winter Issue*, 7-8.

[266] Gay, G.R. & Vega, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 99-102. White, W. (1979). *Relapse as a phenomenon of staff burnout in recovering substance abusers working as counselors*. Rockville, MD: HCS, Inc. Williams, E., Collyer, J., Schaake, I., et al. (1990). Counselor wellness and impaired practice: Survey results of the Kansas Alcoholism and Drug Addiction Counselors Association. *The Counselor*, *January/February*, 9, 39-40.

[267] While relapse is highlighted as a concern for people in recovery working in service roles, the addictions literature is strangely silent about the impairment of persons not identified as "in recovery"—persons whose impairment may spring from AOD-related or other problems. White, W. (2009). The development and mobilization of community resources for the initiation and maintenance of addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-58. St. Germaine, J. (1997). Ethical practices of certified addiction counselors: A national survey of state certification boards. *Alcoholism Treatment Quarterly*, *15*, 63-72.

[268] Strachan, J.G. (1973). Non-alcoholic versus recovered personnel. In G.E. Staub & L.M. Kent (Eds.). *The para-professional in the treatment of alcoholism* (pp. 85-90). Springfield, IL: Charles C. Thomas.

[269] Stratton, R. (1976). "Stratton's Disease": An ailment of alcohologists. *Alcohol Health and Research World*, *Summer*, 27-28.

Role of Risk in Recovery

A unique foundation of P-BRS is the belief that risk is an essential part of recovery and that a life without risk and challenge is a life lived in shackles. Recovering people have the right to take risks and make mistakes, taking full responsibility for personal choices and their consequences. Most of all, they have a right to own their own successes and, at a larger level, to be part of the solution to the very problems that once defined them. The focus of P-BRS is not on preventing all risk—but in supporting people to take the kinds of risks that lead to a productive and meaningful life of recovery within the community. Embedded within the peer recovery culture is the understanding that the same "Go for it!" attitude that fueled recklessness and excess in addiction can be the source of great success and service when it is channeled into a recovery process. The latter risks often involve acts of care, purposeful self-development, and helping encounters with others.

The question of when a person in recovery is "ready" to help others is not a question of timing but a question of type and degree of help. The person with two days' sobriety may have something of great value to offer the person struggling to get through his or her first day sober. One of the consistent threads in the history of recovery is that a most perfect and perfectly timed message can be delivered by the most imperfect of messengers.[270] Professional paternalism, and with it preoccupation with problems, vulnerabilities, risks, and liabilities, can prevent people from taking risks and assuming helping roles. Peer recovery traditions focus instead on risk in service to recovery.[271]

The Value of P-BRSS

In summary, supporters of P-BRSS argue that recovering people in paid and volunteer roles can enhance the long-term recovery of others by:

- sharing the sensitivities, knowledge, skills, and zeal for helping others that are among the fruits of their own recovery from addiction;
- using "street credibility"[272] to exhibit empathy, establish rapport, and engage the most alienated, difficult-to-reach individuals and families affected by alcohol and other drug problems;
- communicating with individuals seeking recovery from a foundation of shared experience and a common language;
- delivering support within a relationship that is free of contempt and marked by mutual respect and honesty;

---

[270] For example, see the early history of AA in Cleveland, where requests for help came so quickly in response to a series of *Cleveland Plain Dealer* articles on AA that members with little sobriety were used to coach others through their first days of sobriety. *White, W. (1998). Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Healty Systems.

[271] Personal communication with Fraser Ross, January, 2009.

[272] Gay, G.R. & Vega, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 99-102.

- understanding and working within the cognitive and behavioral defenses of persons receiving treatment and recovery support services (minimizing cons, hustles, and manipulations);
- serving as a communication bridge between the person seeking help and other professional helpers—mediating the "patients' cultural and subcultural values, behaviors, linguistic metaphors, nonverbal cues, and conceptual frameworks"[273] with the professional culture;
- stirring and sustaining hope through personal charisma and role modeling;
- promoting the benefits of involvement in a formal program of professional treatment and/or recovery;
- linking individuals to particular support groups using the intimate knowledge they have gained through personal participation in these groups;
- linking individuals and families to professionally directed treatment and allied health and human services;
- exhibiting a high degree of commitment ("more than a job"; willingness to go "above and beyond" on behalf of those they serve);
- providing behavioral control (rule enforcement) within treatment milieus,
- giving individuals and families recovery guidance to that is pragmatic, concrete, specific, and experience-based;
- providing sober companionship (a safety net) for the person's first entry into the community as a recovering person;
- guiding the transfer of affiliation from cultures of addiction to local communities of recovery and, when possible, to the mainstream community;
- lowering treatment dropout rates via the provision of collateral support;
- providing sustained post-treatment monitoring, stage-appropriate recovery education, recovery coaching, and, when needed, early re-intervention;
- developing and mobilizing local recovery support services; and
- creating community environments in which recovery can thrive through such activities as recovery community education, recovery advocacy, and support of recovery celebration events.[274]

---

[273] Talbott, J. A., Ross, A. M., Skerrett, A. F., Curry, M. D., Marcus, S. I., Theodorou, H., et al. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, *130*, 805-808.

[274] Bissell, L. (1982). Recovered alcoholic counselors. In E. Pattison & E. Kaufman (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 810-817). New York: Gardner Press. Blume, S. (1977). Role of the recovered alcoholic in the treatment of alcoholism. In B. Kissin & H. Beglieter (Eds.), *The biology of alcoholism, Vol. 5, treatment and rehabilitation of the chronic alcoholic* (pp. 545-565). New York: Plenum Press. Chappel, J.N., Charnett, C.V., & Norris, T.L. (1974). Paraprofessional and professional teamwork in the treatment of drug dependence. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 297-306). Cambridge, MA: Schenkman. Cuskey, W.R. & Premkuman, R. (1973). A differential counselor role model for the treatment of drug addicts. *Health Services Reports*, 88, 663-668. Flores, V.J. & Rice, K.A. (1974). Training viewpoints on paraprofessional counselors.

CRITICISMS OF P-BRSS

Criticisms of P-BRSS, particularly challenges to the early role of the recovering "paraprofessional" counselor in the early 1970s, have included the following:

- Alcohol and drug dependencies are such complex, intractable disorders that only trained professionals are qualified to treat them; counseling by the recovering paraprofessionals "who have assumed counseling positions by obtaining pseudoprofessional credentials" might actually do harm and injury to those they seek to help.[275]
- Traditionally trained counselors who are in recovery may be ineffective in counseling those with less severe AOD problems.[276]
- The current infatuation (early 2000s) with P-BRSS is a regressive step toward the demedicalization and deprofessionalization of addiction treatment.[277]
- People seeking helping roles who have a personal recovery background should not be given preference, because recovery status is not a significant factor in counselor effectiveness as measured by client attraction, engagement, retention, or long-term recovery outcomes. (See Chapter Six.)

In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1048-1050). Cambridge, MA: Schenkman. Gay, G.R. & Vega, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 99-102. King, B.L., Bissell, L.C., & O'Brien, P. (1979). Alcoholics Anonymous, alcoholism counseling, and social work treatment. *Health and Social Work*, *4*, 181-198. Louria, D. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 106-109. Mann, M. (1973). Attitude: Key to successful treatment. In G. E. Staub & L. M. Kent (Eds.), *The paraprofessional in the treatment of alcoholism* (pp. 3-8). Springfield, IL: Charles C. Thomas. McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield, IL: Charles C. Thomas Publisher. Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, *24*(12), 839-841. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment,* 36, 146-58 . Winick, C. (1990). The counselor in drug user treatment, *International Journal of the Addictions*, *25*(12a), 1479-502.

[275] West, P.L., Mustaine, B.L., & Wyrick, B. (2002). Apples and oranges make a nice start for a fruit salad: A response to Culbreth and Borders (1999). *Journal of Counseling and Development*, *80*, 72-76.

[276] Sobell, M. & Sobell, L. (1987). Conceptual issues regarding goals in the treatment of alcohol problems. *Drugs and Alcohol*, *1*(2-3), 1-37.

[277] On the lecture circuit, I frequently am asked by treatment representatives whether peer support programs like CSAT's Recovery Community Service Program and Access to Recovery programs are a precursor to the future de-funding of professionally directed addiction treatment.

- Similar backgrounds within a helper-helpee relationship can lead to "therapeutic scotoma" (blind spots within the helper's visual field).[278]
- Recovering people are prone to countertransference ("biases, prejudices, and distortions" through which they force each helpee into the recovering person's own pathway/style of recovery, repel others with an attitude of self-righteousness, or are personally wounded by the continued addiction of those they seek to help).[279]
- Some recovering people, in spite of their own recovery success, view people addicted to alcohol and/or drugs in moralistic terms and are prone to a "reverse sort of snobbery."[280]
- Self-disclosure of one's recovery status and story in the counseling relationship is clinically ineffective and a breach of professional ethics.[281]
- Recovering people who work as professional helpers have "questionable motives" for seeking helping roles and are at increased risk of burnout and relapse.[282]
- Recovering people working as counselors do not maintain proper clinical documentation and are not as open to supervision as professionally trained counselors.[283]

One of the most consistent criticisms of the role of recovering people in the treatment field is that people in recovery inhibit the development of new knowledge and approaches to the treatment of addiction.

---

[278] Shapiro, E.T. & Pinsker, H. (1973). Shared ethnic scotoma. *American Journal of Psychiatry*, *130*, 1338-1341.

[279] De Angelis, G.G. & Ross, E.A. (1978). A comparison of nonaddict and ex-addict professionals in an adolescent treatment program. *Drug and Alcohol Dependence*, 3(5), 319-329. Kaufman, E. (1978). The use of ex-addicts and other paraprofessionals as mental health workers in prison. *Diseases of the Nervous System*, 37(12), 679-682. LaRosa, J.C., Lipsius, S.H. & LaRosa, J.H. (1974). Experiences with a combination of group therapy and methadone maintenance in the treatment of heroin addiction. *International Journal of the Addictions*, 9, 605-617. Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher. Tournier referred to this process as the "homogenization of a wide diversity of drinking problems." Tournier, R. E. (1979). Alcoholics Anonymous as treatment and as ideology. *Journal of Studies on Alcohol*, *40*, 230-239. .

[280] Rivers, C. (1984). How to survive in a chemical dependency agency. In Lawson, G, Ellius, D. & Rivers, C. (Eds.). *Essentials of Chemical Dependency Counseling*, Aspen, p. 147-190.

[281] This was the rationale that many treatment programs used to prohibit their counselors from providing a factual response to questions regarding their recovery status.

[282] Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596-603.

[283] Siassi, I., Angle, B.P., & Alston, D.C. (1977). Who should be counselors in methadone maintenance programs: Ex-addicts or nonaddicts? *Community Mental Health Journal*, *13*(2), 125-132.

…the most personal and poignant dimension may be that the ex-alcoholic is torn inside himself between a commitment to a view of alcoholism that undergirds his continuing personal stability and a commitment to intellectual and scientific knowledge and its concurrent professional integrity…he may have less personal freedom to look at alcoholism problems dispassionately and perhaps innovate new approaches.[284]

TESTING THE THEORETICAL FOUNDATIONS OF P-BRSS

The key ideas and propositions set forth in this chapter regarding P-BRSS can be viewed as hypotheses that need to be tested in empirical studies of P-BRSS and through the ongoing monitoring of recovery-focused systems-performance measures. The coming chapters summarize findings from existing studies. Examples of performance measures that can be used to test the theoretical foundations of P-BRSS are displayed in Table 7.

Table 7: Performance Measures and P-BRSS Core Ideas

Theoretical Proposition	Example of Performance Measure
Wounded Healer	• Recovery representation (measured by percentage) on governing board, executive staff, direct service staff, and volunteers • Relationship of recovery representation to recovery outcomes
Experiential Knowledge	• Relationship of recovery outcomes to average number of recovering people each person is exposed to during a service episode
Mutual Identification	• Policies encouraging appropriate use of staff/volunteer disclosure of recovery status/story • Frequency of self-disclosure as a helping intervention • Evaluation of effects of helper self-disclosure on helping alliance and recovery outcomes

[284] Pattison, E. (1973). A differential view of manpower resources. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 9-31). Springfield, IL: Charles C. Thomas Publisher.

Theoretical Proposition	Example of Performance Measure
Chronic Illness and Peer Support	• Average number of years/months between first service episode and achievement of first year of sustained recovery—with and without P-BRSS • Quality-of-life measures for individuals and families experiencing chronic substance use disorders—with and without P-BRSS • Percentage of persons who are admitted, retained, and assertively linked to a recommended next level of care • Percentage of persons who maintain continuity of contact within a primary recovery support relationship across levels of care
Charisma	• Percentage of service recipients who attribute early engagement to energy, enthusiasm, and influence of peer helper • Percentage of service recipients who attribute service termination to intrusiveness/paternalism/domination by peer or professional helper
Stigma/Attitudes	• Percentage of individuals receiving P-BRSS who report feeling safe and respected within the peer service relationship • Percentage of clients re-initiating service after a relapse who report being welcomed, respected, and encouraged rather than shamed • Percentage of clients discussing their personal response to the social stigma attached to AOD problems
Helper Therapy Principle	• Percentage of P-BRSS specialists who report that their personal recovery has been enhanced by their work as a P-BRSS specialist • Percentage of P-BRSS staff who have maintained uninterrupted sobriety during their tenure as peer support specialists
Respect for Calling	• Percentage of P-BRSS staff/volunteers who report feeling called to service work with individuals/families seeking recovery
Recovery Management	• Comparison of access, early retention, service dose, service scope, and post-treatment recovery support group participation rates—with and without P-BRSS • Percentage of clients who report that their motivation for recovery was sustained as a result of the peer support relationship

Theoretical Proposition	Example of Performance Measure
Ecology of Recovery	• Percentage of individuals for whom family recovery capital was evaluated • Percentage of individuals with family members involved in the recovery support process • Average number of family members per client receiving P-BRSS • Percentage of clients visited by peer/professional staff in the client's natural living environment • Percentage of individuals for whom community recovery capital was formally evaluated
Cultures of Addiction/Recovery	• Percentage of clients for whom degree of enmeshment in culture of addiction was evaluated • Percentage of clients who were assertively linked to indigenous communities of recovery
Primacy of Recovery	• Percentage of P-BRSS specialists involved in weekly personal recovery support activities • Annual lapse/relapse relapse rate of P-BRSS specialists (staff and volunteers)
Dangers of Professionalism and Anti-Professionalism	• Percentage of P-BRSS programs that retain P-BRSS service mission and maintain fidelity to core service values
Continuity of Support	• Percentage of individuals who are admitted and retained within a next level of recommended care (connection as a percentage of assertive linkage attempts). • Percentage of individuals involved in two or more levels of care who report continuity of contact through a single P-BRSS relationship across levels of care
Minimization of Harm	• Number of complaints alleging harm filed by individuals/ families receiving P-BRSS • Percentage of clients who experience measurable deterioration in health and functioning during the service process
Stewardship/Cost Effectiveness	• Evaluation of cost offsets resulting from shortened addiction careers (reduced readmissions, reduced health care costs, reduced incarceration rates) • Cost-benefit analysis for the P-BRSS infrastructure and service delivery

Table 7 illustrates that many of the constructs that underlie P-BRSS could be tested in formal scientific studies and through simple, program-level monitoring processes. The next chapter begins our exploration of what scientific studies have revealed to-date about peer-based recovery support.

Chapter Four

Scientific Evaluation of Peer-based Support: Studies of the Effects of Participation in Recovery Mutual-aid Societies

Summary of Key Findings

- 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, but studies of Internet-based recovery support services are at an early stage.

- The potential positive effects of recovery mutual-aid participation are often not achieved due to weak linkage procedures and high early dropout rates.

There is a substantial body of research literature confirming the role of social support, particularly recovery-specific social support, on the long-term resolution of severe alcohol- and other-drug problems.[285] Put simply, the odds of recovery rise in tandem with social network support for abstinence and decline with the increased density of heavy AOD users in one's social network.[286] The presence or absence of family and peer support for abstinence exerts a particularly powerful influence on the recovery outcomes of adolescents treated for substance use disorders.[287] In this and proceeding chapters, we will explore how different types of peer support influence the prospects of long-term recovery.

In spite of the long history of organized peer support in addiction recovery, scientific studies of the effects of peer support on long-term recovery are limited in scope and methodological rigor. Studies to-date fall into three general topical categories, which we will address in this and coming chapters: 1) the effects of participation in recovery mutual-aid societies, 2) the effects of participation in other recovery community support institutions, and 3) studies of recovering people working in multiple service roles in addiction treatment and allied health organizations.

As noted earlier, there are numerous limitations that prevent drawing definitive conclusions on critical questions related to the design and delivery of peer-based recovery support. These limitations include questions toward which no studies have been directed and studies that suffer from small sample sizes, non-representative samples, selection bias, lack of control groups, lack of randomization, and reliance on self-report without biomedical or collateral corroboration of abstinence. Studies to-date are also limited by their primary focus on one recovery mutual-aid framework (Alcoholics Anonymous), AA-

---

[285] Beattie, M.C. & Longabaugh, R. (1999). General and alcohol-specific social support following treatment. *Addictive Behaviors*, *24*, 593-606. Groh, D.R., Jason, L.A., Davis, M.I., Olson, B.D., & Farrari, J.R. (2007). Friends, family, and alcohol abuse: An examination of general and alcohol-specific social support. *The American Journal on Addictions*, *16*, 49-55. Longabaugh, R., Wirtz, P.W., Zweben, A. & Stout, R.L. (1998). Network support for drinking. Alcoholics Anonymous and long-term matching efforts. *Addiction, 93*, 1313-1333.

[286] Bond, J., Kaskutas, L.A., & Weisner, C. (2003). The persistent influence of social networks and Alcoholics Anonymous on abstinence. *Journal of Studies on Alcohol*, *64*(4), 579-588. 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. Zywiak, W., Longabaugh, R., & Wirtz, P.W. (2002). Decomposing the relationships between permanent social network characteristics and alcohol outcome. *Journal of Studies on Alcohol*, *63*, 114-121. Mohr, C., Averna, S., Kenny, D., & Del Boca, F. (2001). "Getting by (or getting high) with a little help from my friends": An examination of adult alcoholics' friendships. *Journal of Studies on Alcohol*, *62*(5), 637-645. Weisner, C., Matzger, H., & Kaskutas, L. A. (2003). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. *Addiction*, *98*(7), 901-911.

[287] 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.

influenced treatment models, and treatment population responses to AA during the earliest stages of recovery.[288] Most studies of people in recovery working as addiction counselors are limited by having been conducted in an era in which most addiction counselors working in addiction treatment possessed neither significant education or training—a status that has changed dramatically over the past 40 years.

The discussions in the coming chapters highlight studies that shed light on P-BRSS and discuss critical issues related to P-BRSS that deserve further scientific investigation. As we proceed, it would be best if the reader considered the findings presented as "true" of some people in some places at a particular point in time. The collective findings of the studies reviewed tell a story, but it is not the whole story.

LIMITED SCOPE OF RESEARCH ON RECOVERY MUTUAL-AID SOCIETIES

Most of what we know scientifically about the effects of participation in addiction recovery mutual-aid societies on long-term recovery outcomes is based on studies of adult members of Alcoholics Anonymous (AA) and, to a lesser extent, Narcotics Anonymous (NA).[289] Early studies of AA suffered from weak methodological rigor, which limited the value of their findings,[290] but the quality of AA studies has improved markedly in the past decade.[291] In spite of these improvements, there is still great controversy surrounding AA research and the wildly divergent conclusions drawn from that research. (See Kaskutas, in press, for the latest review.)[292]

Studies of alternative recovery mutual-aid societies have begun to appear in addiction science journals, but these early reports are primarily descriptive and do not reflect long-term recovery outcome studies. This literature includes papers on new 12-Step programs for drug dependencies other than alcohol and

---

[288] Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, *57*(1), 65-72.

[289] Brown, B.S., O'Grady, K.E., Farrell, E.V., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, *27*(1), 147-160. Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, UK: Cambridge University Press.

[290] Emrick, C. D., Tonigan, J. S., Montgomery, H., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. McCrady & W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 41-78). Piscataway, NJ: Rutgers Center for Alcohol Studies. Kownascki, R.J. & Shadish, W.R. (1999). Does Alcoholics Anonymous work? The results from a meta-analysis of controlled experiments. *Substance Use and Misuse*, *34*(13), 1897-1916. Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, *57*(1), 65-72.

[291] Humphreys, K. (2006). The trial of Alcoholics Anonymous. *Addiction*, *101*, 617-618.

[292] Kaskutas, L.A. (in press). Alcoholism Anonymous effectiveness: Faith meets science. *Journal of Addictive Diseases*.

narcotics,[293] Women for Sobriety,[294] Secular Organizations for Sobriety,[295] Rational Recovery,[296] LifeRing Secular Recovery,[297] SMART Recovery®,[298] and Moderation Management.[299] Particularly striking is the lack of scientific literature—even descriptive studies—on faith-based addiction recovery support groups.

There are multiple methodological challenges in studying mutual-aid recovery support groups, but perhaps the most significant is that "the more the researcher controls the group for research purposes, the less what is being evaluated is truly a self-help group as opposed to a professionally controlled paraprofessional helping program."[300] Recent enhancements in the methodological quality of studies of recovery support groups (for example,

---

[293] Donovan, D.M. & Wells, E.A. (2007). "Tweaking 12-Step": The potential role of 12-Step self-help group involvement in methamphetamine recovery. *Addiction*, *102*(Suppl. 1), 121-129. Weiss, R.D., Griffin, M.L., Gallop; R., Onken, L.S., Gastfriend, D.R., Daley, D., et al. (2000). Self-help group attendance and participation among cocaine-dependent patients. *Drug and Alcohol Dependence*, *77*, 177-84.

[294] Kaskutas, L. (1992). Beliefs on the sources of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems*, *Winter*, 631-648. Kaskutas, L. (1994). What do women want out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment, 11*(3), 185-195.

[295] Connors, G.J. & Dermen, K.H. (1996). Characteristics of participants in Secular Organization for Sobriety. *American Journal of Alcohol and Drug Abuse*. *19*(4), 281-295.

[296] Rational Recovery (RR) is listed here as a mutual recovery support group because it served that function during its early history, spreading to more than 700 cities in the United States. Jack Trimpey, the founder of RR, later abandoned the use of groups, and a split within RR in 1994 led to the creation of SMART Recovery, which does continue to function as a recovery mutual-aid society with local group meetings. Today, Rational Recovery Systems, Inc. is a for-profit organization that promotes self-recovery through the use of the addictive voice recognition technique (AVRT). Ellis, A. (1992). Rational Recovery and the addiction to 12-Step therapies. *Humanist, 52*(6), 33-35. Galanter, M., Egelko, S., & Edwards, H. (1993). Rational Recovery: Alternative to AA for addiction? *The American Journal of Drug and Alcohol Abuse*, *19*(4), 499-510. Schmidt, E. (1996). Rational Recovery: Finding an alternative for addiction treatment. *Alcoholism Treatment Quarterly*, *14*(4), 47-57. Schmidt, E.A., Carns, A, & Chandler, C. (2001). Assessing the efficacy of Rational Recovery in the treatment of alcohol/drug dependency. *Alcoholism Treatment Quarterly*, *19*(1), 97-106.

[297] White, W. & Nicolaus, M. (2005). Styles of secular recovery. *Counselor*, *6*(4), 58-61.

[298] Horvath, A. (1999-2000). SMART Recovery. *International Journal of Self Help and Self Care*, *1*(2), 163-169.

[299] Humphreys, K. (2003). Alcohol & drug abuse: A research-based analysis of the moderation management controversy. *Psychiatric Services*, *54*, 621-622. Humphreys, K. & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol, 62*(4), 528-532. Klaw, E. & Humphreys, K. (2000). Life stories of Moderation Management mutual help group members. *Contemporary Drug Problems, 27*, 779-803. Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy, 17*, 295–303.

[300] Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

improved measurement, longer follow-up periods, higher follow-up rates, and the use of comparison groups) are generating replicated findings that allow the articulation of preliminary conclusions related to the operation and effectiveness of such groups, particularly Alcoholics Anonymous.[301] The extent to which findings from AA can be generalized to other recovery support societies is unclear.

ROLE OF MUTUAL AID IN RECOVERY OUTCOMES

Participation in addiction recovery support groups typically enhances long-term recovery outcomes.[302] Recovery support group participation is also linked to increased global (physical, emotional, relational, occupational) health and functioning,[303] as well as reduced mortality rates,[304] particularly rates of suicide.[305]

---

[301] Kelly J. F. & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J. R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

[302] Emrick, C. D., Tonigan, J. S., Montgomery, H., & Little, L. (1993). Alcoholics Anonymous: What is currently known? In B. McCrady & W. R. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 41-78). Piscataway, NJ: Rutgers Center for Alcohol Studies. Fiorentine, R. (1999). After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, *25*(1), 93-116. Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B. et al., (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158. Kisson, W., McLeod, C., & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, *26*, 311-23. McKellar, J., Stewart, E., & Humphreys, K. (2003). Alcoholics Anonymous involvement and positive alcohol-related outcomes: Cause, consequences, or just a correlate? A prospective 2-year study of 2,319 alcohol-dependent men. *Journal of Consulting and Clinical Psychology*, *71*(2), 302-308. Morgenstern, J., Bux, D.A., Jr., Labouvie, E., Morgan, T., Blanchard, K.A., & Muench, F. (2003). Examining mechanisms of action in 12-Step community outpatient treatment. *Drug and Alcohol Dependence*, *72*, 237-247. Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, *65*(5), 768-777. Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, *60*(4), 437-447. Vaillant, G.E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98,* 1043-1051.

[303] Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, UK: Cambridge University Press.

[304] Cuupers, P., Riper, H., & Lemmers, L. (2004). The effects of brief interventions for problem drinking: A meta-analysis. *Addiction*, *99*, 839-845. Timko, C., DeBenedetti, A., Moos, B.S., & Moos, R.H. (2006). Predictors of 16-year mortality among individuals initiating help-seeking for an alcoholic use disorder. *Alcoholism: Clinical and Experimental Research*, *30*(10), 1711-1720.

[305] Mann, R.E., Zalcman R., Smart, R., Rush, B.R., & Suurvali, H. (2006). Alcohol consumption, Alcoholics Anonymous membership, and suicide mortality rates, Ontarion, 1968-1991. *Journal of Studies on Alcohol*, *67*, 445-453.

In 1977, Emrick, Larsen, and Edwards identified three principles related to AA and professional treatment involvement and drinking outcomes, principles that have stood the test of time: 1) *AA is more effective than professional treatment in helping alcoholics maintain total abstinence*, 2) *professional treatment appears to be more effective than AA in helping alcoholics reduce drinking without becoming totally abstinent*, and 3) *both peer and professional helpers appear to be needed, because each is helpful only to some people*.[306]

But how much benefit can one expect from AA participation? Humphreys and Kaskutas recently reviewed the latest research studies on such effects and drew the following conclusions:

> *These studies show that among patients who receive treatment, supplemental involvement in 12-Step mutual help organizations has quite large benefits, increasing abstinence rates by 25-100%. The health care cost reductions, on the order of thousands of dollars per patient, are also of note. Importantly, these findings are not due to self-selection, they derive from randomized trials and quasi-experimental studies, and if anything, the randomized trials show greater not lesser benefits to AA/NA participation than do uncontrolled studies….What about an addicted person who is not in treatment—how much will they benefit? This is a hard question to answer, but one useful source of data is Moos and colleagues' series of studies of individuals seeking help for alcohol problems for the first time. One study in this research program compared 135 individuals who went to AA first with 66 broadly comparable people who chose to go to professional outpatient treatment. By three year follow-up, both groups had decreased their ethanol consumption and alcohol dependence symptoms by about 70%. Most of the individuals who started in AA stayed in AA and did not subsequently enter professional treatment, which suggests that large benefits of AA participation are not limited to individuals who combine treatment with mutual help group involvement*.[307]

Data from the 2006 and 2007 National Survey on Drug Use and Health reveal that approximately 5 million people a year (2% of the population over age 12) attend recovery support groups to support their recovery from alcohol and other drug-related problems. These individuals represent a high degree of

---

[306] Emrick, C.D., Lassen, C.L., & Edwards, M.T. (1977). Nonprofessional peers as therapeutic agents. In A.S. Gurman & A.M. Rasin (Eds.), *Effective psychotherapy: A handbook of research* (2nd edition, pp. 120-161). Elmsford: Pergamon. Elal-Lawrence, G. Slade, P.D., & Dewey, M.E. (1986). Predictors of outcome type in treated problem drinkers. *Journal of Studies on Alcohol, 47*, 41-47. Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-Step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, *8*(1), 45-59. Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

[307] Humphreys, K. & Kaskutas, L.A. (2007). Continuity of care guidelines for participation in mutual help organizations before, during and after addiction treatment. Presented at the the 2nd Consensus Conference of the Betty Ford Institute, October 3-4, 2007.

diversity by gender, age, race/ethnicity, size of community, and family income. Of those attending recovery support groups in the past year in the U.S., 45.3% attended to resolve alcohol problems, 21.8% to resolve an illicit drug problem, and 33% to resolve problems related to both alcohol and illicit drug use. Of those reporting past-year attendance, 45.1% reported abstinence in the past month, and 54.9% reported continued substance use.[308]

VARIABILITY OF RESPONSE

The response to addiction recovery mutual-aid groups is not uniform.[309] People exposed to a particular recovery support group may respond fully, partially, or not at all.[310] For example, in a study of client referrals to AA during treatment, 31% had an optimal response, 43% a partial response, and 22% a non-response, with the non-responders having the worst post-treatment recovery outcomes.[311] Some studies have linked higher levels of AA affiliation with higher levels of problem severity among adults[312] and adolescents.[313] Brown, O'Grady, Farrell, and colleagues[314] studied recovery support group affiliation patterns of clients in outpatient drug treatment who had been referred from the criminal justice system. Higher participation rates were related to greater problem severity (as measured by prior treatment and greater criminal involvement) and earlier age of onset of alcohol use.

Patterns of affiliation differ widely among those who do affiliate with recovery mutual-aid groups. Kaskutas and colleagues[315] described four such

---

[308] Office of Applied Studies (2008) Participation in self-help groups for alcohol and illicit drug use: 2006 and 2007. *The NSDUH Report*, November 13, Substance Abuse and Mental Health Services Administration.

[309] Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, *57*(1), 65-72.

[310] Caldwell, P.E. & Cutter, H.S. (1998). Alcoholics Anonymous affiliation during early recovery. *Journal of Substance Abuse Treatment*, *15*, 221-28. Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-Step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, *8*(1), 45-59.

[311] Morgenstern, J., Kahler, C. W., Frey, R. M., & Labouvie, E. (1996). Modeling therapeutic response to 12-Step treatment: Optimal responders, nonresponders, partial responders. *Journal of Substance Abuse*, *8*(1), 45-59.

[312] Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., et al. (2002). AA participation 10 years after Project MATCH treatment: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, *26*(Supplement), 42A. Tonigan, J.S., Toscova, R., & Miller, W.R. (1996). Meta-analysis of the literature on Alcoholics Anonymous. *Journal of Studies on Alcohol*, *57*(1), 65-72.

[313] Kelly, J.F., Myers, M.G., & Brown, S.A. (2002). Do adolescents affiliate with 12-Step groups? A multivariate process model of effects. *Journal of Studies on Alcohol, 63*, 293-304.

[314] Brown, B.S., O'Grady, K.E., Farrell, E.V., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, *27*(1), 147-160.

[315] Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

patterns: 1) low AA attendance (participation in only a small number of meetings during first year following treatment, 2) medium AA attendance (attending a high number of meetings but only for a short period of time), 3) high attendance (increasing level of involvement during the first five years), and 4) moderate but steady attendance. They found abstinence rates increasing and decreasing in tandem with increased and decreased meeting attendance, but also documented the potential of sustained sobriety for some people following cessation of regular AA meeting attendance. They referred to this latter pattern as "positive disengagement."[316]

The growing varieties of recovery support groups and the variability of personal responses to each group suggests the use of a philosophy of choice, through which addiction professionals and peer support specialists review recovery support options with each person to achieve the best person-group match.[317] Individuals may initiate and sustain recovery within a single recovery support group, concurrently participate in more than one recovery support group, or initiate recovery through one framework and then shift to another framework to maintain that recovery. The latter is illustrated by African American women shifting from AA/NA for recovery initiation to the church as their primary source of support for recovery maintenance.[318] Although at a philosophical level some recovery support groups appear opposed to one another, at the individual level, it is common to see people simultaneously attending "opposing" mutual-aid groups such as Women for Sobriety and AA.[319]

EFFECTIVENESS ACROSS DIVERSE POPULATIONS

Recent studies confirm that affiliation and recovery rates within AA also extend to:

---

[316] Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

[317] White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51. White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

[318] Kaskutas, L. (1992). Beliefs on the sources of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems*, *Winter*, 631-648. Kaskutas, L. (1994). What do women want out of self-help? Their reasons for attending Women for Sobriety and Alcoholics Anonymous. *Journal of Substance Abuse Treatment, 11*(3), 185-195; Kelly, J.F. & Yeterian, J.D. (2008). Mutual-help groups for Dually-Diagnosed Individuals: Rationale, Description, and Review of the Evidence, Journal of Groups in Addiction and Recovery, 3, 3/4, 217-242. White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[319] Kaskutas, L. (1992). Beliefs on the sources of sobriety: Interactions of membership in Women for Sobriety and Alcoholics Anonymous. *Contemporary Drug Problems*, Winter, p. 631-648.

- people dependent upon drugs other than, and in addition to, alcohol;[320]
- adolescent and adult women;[321]
- people of color;[322]
- young people;[323]
- people with co-occurring psychiatric disorders;[324] and

---

[320] Fiorentine, R. (1999). After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, *25*(1), 93-116. Siegal, H.A., Li, L., & Rapp, R.C. (2001). Abstinence trajectories among treated crack cocaine users. *Addictive Behaviors*, *26*, 1-13. Weiss, R.D., Griffin, M.L., Gallop. R., Onken, L.S., Gastfriend, D.R., Daley, D., et al. (2000). Self-help group attendance and participation among cocaine-dependent patients. *Drug and Alcohol Dependence*, *77*, 177-84. Witbrodt, J. & Kaskutas, L.A. (2005). Does diagnosis matter? Differential effects of 12-Step participation and social networks on abstinence. *The American Journal of Drug and Alcohol Abuse, 31*, 685-707.

[321] Hillhouse, M.P. & Fiorentine, R. (2001). 12-Step program participation and effectiveness: Do gender and ethnic differences exist? *Journal of Drug Issues*, *31*(3), 767-780. Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, *32*(8), 1-11. Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research, 30*(8), 1381-1392. Sanders, J.M. (2006). Women and the twelve steps of Alcoholics Anonymous: A gendered narrative. *Alcoholism Treatment Quarterly*, 24(3), 3-29.

[322] Caetano, R. (1993). 1993 Ethnic minority groups and Alcoholics Anonymous: A review. In B. McCrady & W. Miller (Eds.), *Research on Alcoholics Anonymous: Opportunities and alternatives* (pp. 209-231). New Brunswick, NJ: Rutgers Center of Alcohol Studies. Humphreys, K., Mavis, B. E., & Stöffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, *11*, 165-180. Humphreys, K., Mavis, B. & Stofflemayr, B. (1991). Factors predicting attendance at self-help groups after substance abuse treatment: Preliminary findings. *Journal of Consulting and Clinical Psychology,* 59(4), 591-593.

[323] Hsieh, S., Hoffman, N.G., & Hollister, D.C. (1998). The relationship between pre-, during-, post-treatment factors, and adolescent substance abuse behaviors. *Addictive Behaviors*, *23*(4), 477-488. Hohman, L., LeCroy, C.W., & Winston, C. (1996). Predictors of adolescent AA affiliation. *Adolescence*, *31*(122), 339-352. Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, *14*, 376-389. Kelly, J.F., Myers, M.G., & Rodolico, J. (2008). What do adolescents exposed to Alcoholics Anonymous think about 12-Step groups? *Substance Abuse*, *29*(2), 53-72. Brown, S.A. & Ramo, D.E. (2006). Clinical course of youth following treatment for alcohol and drug problems. In H.A. Liddle & C.L. Rowe (Eds.), *Adolescent substance abuse: Research and clinical advances* (pp. 79-103). Cambridge, NY: Cambridge University Press. Tonigan, J.S., Connors, G.J., & Miller, W.R. (1998). Special populations in Alcoholics Anonymous. *Alcohol Health and Research World*, *22*(4), 281-285.

[324] Bogenschutz, M.P. & Akins, S.J. (2000). 12-Step participation and attitudes toward 12-Step meetings in dual diagnosis patients. *Alcoholism Treatment Quarterly*, *18*(4), 31-45. Chi, F.W., Satre, D.D., & Weisner, C. (2006). Chemical dependency patients with cooccurring psychiatric diagnoses: Service patterns and 1-year outcomes. *Alcoholism: Clinical and Experimental Research*, *30*(5), 851-859. Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R.

- people without religious or spiritual orientation.[325]

These findings confirm that AA has matured beyond its origins as a program for white, middle-aged, middle-class Protestant men. Studies have actually found that women participate more and benefit more from 12-Step recovery support groups following treatment than do men.[326] Similarly, studies of AA and/or NA participation following treatment show that African Americans are more likely than Caucasians to participate in AA and/or NA following treatment.[327]

The most recent evidence available on representation of women, people of color, and young people, as revealed in available recovery fellowship membership surveys, is displayed in Table 8. Degree of diversity in social class is reflected in a combination of three factors variably reported in the membership surveys: education, employment, and income.

(2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research, 30*(8), 1381-1392. Laudet, A., Magura, S., Vogel, H.S., & Knight, E. (2000). Addiction services: Support, mutual aid and recovery from dual diagnosis. *Community Mental Health Journal*, *36*(5), 457-476. Ouimette, P., Humphreys, K., Moos, R,H., Finney, J.W., Cronkite, R., & Federman, B. (2001). Self-help group participation among substance use disorder patients with posttraumatic stress disorder. *Journal of Substance Abuse Treatment, 20*(1), 25-32. Rychtarik, R.G., Connors, G.J., Dermen, K.H., & Stasiewics, P.R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, *61*, 134-138. Swift, R.M., Duncan, D., Niremberg, T., & Femino, J. (1998). Alcoholic patients' experience and attitudes on pharmacotherapy for alcoholism. *Journal of Addictive Diseases*, *17*, 35-47. Timko, C. & Sempel, J.M. (2004). Intensity of acute services, self-help attendance and one-year outcomes among dual diagnosis patients. *Journal of Studies on Alcohol*, *65*, 274-282. Tonigan, J.S. & Kelley, J.F. (2004). Beliefs about AA and the use of medications: A comparison of three groups of AA-exposed alcohol dependent persons. *Alcoholism Treatment Quarterly*, *22*(2), 67-78.

[325] Brown, B.S., O'Grady, K.E., Farrell, E.V., Flechner, I.S., & Nurco, D.N. (2001). Factors associated with frequency of 12-Step attendance by drug abuse clients. *American Journal of Drug and Alcohol Abuse*, *27*(1), 147-160. Connors, G.J., Tonigan, S., & Miller, W. (2001). *Religiosity and responsiveness to alcoholism treatments*. Bethesda, MD: Department of Health and Human Services. Winzelberg, A. & Humphreys, K. (1999). Should patients' religiosity influence clinicians' referral to 12-Step self-help groups? Evidence from a study of 3018 male substance abuse patients. *Journal of Counseling and Clinical Psychology*, *67*(5), 790-794.

[326] . Del-Boca, F.K. & Mattson, M. E..(2002). The gender matching hypothesis. In: Project MATCH hypotheses: Results and causal chain analyses, R. Longabuath & P.W. Wirtz (Eds.). USHHS, Rockville, MD. Moos, R.H., Moos, B.S., & Timko, C. (2006). Gender, treatment and self-help in remission from alcohol use disorders. *Clinical Medicine & Research*, *4*(3), 163-74. Grella, C.E., Scott, C.K., & Foss, M.A. (2005). Gender differences in long-term drug treatment outcomes in Chicago PETS. *Journal of Substance Abuse Treatment*, *28*, S3-S12. Timko, C., Moos, R.H., Finney, J.W., & Connell, E.G. (2002). Gender differences in help-utilization and the 8-year course of alcohol abuse. *Addiction*, *97*, 877-889.

[327] Harris, A.H.S., McKellar, J.D., Moos, R.H., Schaefer, J.A., & Cronkite, R.C. (2006). Predictors of engagement in continuing care. *Drug & Alcohol Dependence*, *84*, 93-101. Humphreys, K., Mavis, B. E., & Stöffelmayr, B. E. (1994). Are twelve-step programs appropriate for disenfranchised groups? Evidence from a study of posttreatment mutual help group involvement. *Prevention in Human Services*, *11*, 165-180.

Table 8: Demographic Characteristics of Recovery Mutual-aid Societies

Membership Characteristics	AA[328] (2007)	NA[329] (2007)	CA[330] (2007)	SOS[331] (1992)	WFS[332] (1992a.b)	LSR[333] (2005)	MM[334] (2004)
Male	67%	55%	65%	73.4%	0%	58%	44%
Female	33%	45%	35%	36.6%	100%	42%	66%
Caucasian	85.1%	70%	68%	99.4%	98%	77%	98%
African American	5.7%	11%	19%	*	1%	5%	*
Hispanic	4.8%	11%	6%	*	0%	4%	*
Asian American	2.8%		1%	*	0%	1%	*
Native American	1.6%		5%	*	0%	1%	*
Other (or no answer)		8%	1%	.6%	0%	12%	2%
Youth representation (under age 21)	2.3%	3%	1% under 18; 8% 18-24	0%	* Average member-ship age is 46	Less than 1%	% under 21 not available; Mean age of 44 years

[328] Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

[329] Narcotics Anonymous (2008). *Information about NA*. Retrieved August 29, 2008 from http://www.na.org/basic.htm.

[330] Cocaine Anonymous (2007). *Cocaine Anonymous Public Information Fact File: Results from the 2007 survey*. Los Angeles: CA: Cocaine Anonymous World Services Office, Inc.

[331] Connors, G.J. & Dermen, K.H. (1996). Characteristics of participants in Secular Organization for Sobriety. *American Journal of Alcohol and Drug Abuse*, *19*(4), 281-295.

[332] Kaskutas, L.A. (1992). Women for Sobriety: Doctoral dissertation, School of Public Health, University of California, Berkeley.

[333] LifeRing Secular Recovery (2008). *2005 LifeRing Participant Survey: Results*. Retrieved October 7, 2008 from http://www.unhooked.com/survey/2005_lifering_participant_survey.htm.

[334] Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy, 17*, 295–303.

Membership Characteristics	AA[335] (2007)	NA[336] (2007)	CA[337] (2007)	SOS[338] (1992)	WFS[339] (1992a.b)	LSR[340] (2005)	MM[341] (2004)
Education (% with at least one year of college)	*	*	50%	79.5%	66%	78%	94%
Employment	*	79%	*	62.2%	*	*	80%
Average Annual Income	*	*	*	$31,000	$23,000	*	76% $50,000+

* Data not available in latest published survey

These surveys suggest that the representation of women in AA parallels the 3:1 male/female alcohol problem ratio found in the general population[342] and that representation of women is even higher in other recovery mutual-aid groups. People of color, particularly African Americans and Hispanics, increasingly participate in AA and NA, but there is a marked need for studies on their degree of participation in non-12-Step recovery support groups, particularly faith-based recovery support groups. Social class is not collected in AA and NA surveys, but data from other secular groups suggest that these alternatives may attract a greater proportion of people from higher educational and income levels.

As noted earlier, many people with co-occurring psychiatric and substance use disorders actively and successfully participate in mainstream recovery support meetings. Such affiliation is less likely for those with the most severe of these disorders (psychosis), and those who attend do face special issues within and obstacles to their recovery.[343] These unique needs have

---

[335] Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

[336] Narcotics Anonymous (2008). *Information about NA*. Retrieved August 29, 2008 from http://www.na.org/basic.htm.

[337] Cocaine Anonymous (2007). *Cocaine Anonymous Public Information Fact File: Results from the 2007 survey*. Los Angeles: CA: Cocaine Anonymous World Services Office, Inc.

[338] Connors, G.J. & Dermen, K.H. (1996). Characteristics of participants in Secular Organization for Sobriety. *American Journal of Alcohol and Drug Abuse*, *19*(4), 281-295.

[339] Kaskutas, L.A. (1992). Women for Sobriety: Doctoral dissertation, School of Public Health, University of California, Berkeley.

[340] LifeRing Secular Recovery (2008). *2005 LifeRing Participant Survey: Results*. Retrieved October 7, 2008 from http://www.unhooked.com/survey/2005_lifering_participant_survey.htm.

[341] Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy, 17*, 295–303.

[342] NIAAA (1990). *Alcohol and Health. 7th Special Report to the U.S. Congress.* Washington, DC: U.S. Government Printing Office.

[343] Bogenschutz, M.P. & Akins, S.J. (2000). 12-Step participation and attitudes toward 12-Step meetings in dual diagnosis patients. *Alcoholism Treatment Quarterly*, *18*(4), 31-45. Kelly, J.F. McKellar, J.D. & Moos, R. (2003). Major Depression in Patients with Substance Use

spawned three specialty recovery support groups: Dual Recovery Anonymous (DRA), Dual Disorders Anonymous (DDA), and Double Trouble in Recovery (DTR). DTR has been subjected to the most rigorous research.

DTR members in New York City report a broad spectrum of past drugs used (alcohol, marijuana, cocaine, non-prescribed pills, crack, heroin, and other drugs in order of prevalence) and a broad spectrum of past psychiatric diagnoses (unipolar depression, schizophrenia, bipolar disorder, anxiety disorder/phobia, and post-traumatic stress disorder, in order of prevalence). More than half of DTR members have multiple prior psychiatric diagnoses, and the majority have prior substance use and psychiatric treatment. Past-year substance use is very low among DTR members—from 2-10% across drug choices. Seventy-six percent of DTR members currently take medications for the management of psychiatric illness, 73% of members have attended DTR for more than a year, and 90% attend at least one DTR meeting a week.[344]

Several factors are associated with positive outcomes in DTR: enhanced internal locus of control and sociability are linked to DTR affiliation; and helper therapy (sponsoring others), reciprocal learning (mutual sharing of "experience, strength and hope"), spirituality, and hope are linked to sustained alcohol/drug abstinence and other health-promoting behaviors.[345] The effects of DTR participation in these studies must be viewed in light of the finding that three-quarters of DTR members also attend traditional (AA/NA) 12-Step groups.[346]

COST-EFFECTIVENESS

Studies of participation in recovery support groups following addiction treatment have concluded that such participation reduces continuing care costs[347] and post-treatment health care costs.[348] Related to such cost reductions are the facts that AA and other recovery support groups are geographically accessible (particularly true of AA and NA), are available on a 24-hour basis

---

Disorders: Relationship to 12-Step self-help involvement and substance use outcomes. Addiction, 98, 4, 499-508.

[344] Vogel, H.S., Knight, E., Laudet, A.B., & Magura, S. (1998). Double trouble in recovery: Self-help for people with dual diagnoses. *Psychiatric Rehabilitation Journal*, *21*(4), 356-364.

[345] Magura, S., Knight, E., Vogel, H.S., Mahmood, D., Laudt, A.B., & Rosenblum, A. (2003). Mediators of effectiveness in dual-focus self-help groups. *American Journal of Drug and Alcohol Abuse*, *29*(2), 301-322. Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., Vogel, H.S., & Knight, E.L. (2003). Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors*, *28*, 399-413.

[346] Magura, S. (2008). Effectiveness of dual focus mutual aid for co-occurring substance use and mental health disorders: A review and synthesis of the "Double Trouble" in Recovery evaluation. *Substance Use and Misuse*, 43(12), 1904-1926.

[347] Humphreys, K. & Moos, R.H. (2001). Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care: A quasi-experimental study. *Alcoholism: Clinical and Experimental Research*, *255*, 711-6.

[348] Humphreys, K. & Moos, R.H. (1996). Reduced substance-related health care costs among voluntary participants in Alcoholics Anonymous. *Psychiatric Services*, *47*(7), 709-713.

without cost, and do not require time away from work.[349]

Studies of recovery mutual-aid participation by people with co-occurring substance use and psychiatric disorders show that such participation enhances medication compliance and reduces the incidence and cost of hospitalization.[350] Humphreys and Moos[351] sum up the work to-date:

> *Certain tasks supportive of recovery, such as encouragement, social activities, friendship, monitoring and spiritual support, can probably be accomplished by peer-based services as well as they can by health care professionals, and at greatly reduced cost. This has a 2-fold benefit: greater likelihood of long-term recovery for the addicted individual and greater targeting of scarce professional resources to those patients who require such assistance….self-help group involvement is a useful method of extending the benefits of treatment while lowering its ongoing costs.*

THE QUESTION OF HARM (IATROGENESIS)

Harm done in the name of help is a pervasive theme in the history of addiction treatment and recovery.[352] It is thus appropriate to raise the question whether any aspects of recovery support group participation can result in harm. Allegations of such injury have primarily targeted AA, through a series of books,[353] articles,[354] and anti-AA web sites.[355]

---

[349] Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research, 30*(8), 1381-1392. Pagano, M.E., Friend, K.B., Tonigan, J.S., & Stout, R.L. (2004). Helping others in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol*, *65*, 766-773.

[350] Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services*, *53*(3), 310-316.

[351] Humphreys, K. & Moos, R.H. (2007). Encouraging posttreatment self-help group involvement to reduce demand for continuing care services: Two year clinical and utilization outcomes. *Alcoholism: Clinical and Experimental Research*, *31*(1), 64-68.

[352] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W.L. & Kleber, H.D. (1998). Preventing harm in the name of help: A guide for addiction professionals. *Counselor, 9*(6), 10-17.

[353] Bufe, C. (1991). *Alcoholics Anonymous: Cult or cure?* San Francisco: Sharp Press. Fransway, R. (2000). *12-Step horror stories*. Tucson, AZ: See Sharp Press. Gilliam, M. (1999). *How A.A. failed me*. New York: William Morrow. Peele, S. (1989). *The diseasing of America.* Lexington, MA: Lexington, Books. Ragge, K. (1998). *The real AA: Behind the myth of 12-Step recovery.* Tucson, Arizona: Sharp Press.

[354] Ellis, A. (1985). Why Alcoholics Anonymous is probably doing more harm than good by its insistence on a higher power. *Employee Assistance Quarterly*, *1*(1), 95-97. Hooked on recovery: The tyranny of the self-help movement. San Francisco Examiner's *Sunday Image* magazine, June 28, 1992. Rieff, D. (1991). Victims all? Recovery, co-dependency, and the art of blaming somebody else. *Harpers*, *October*, 49-56.

Collectively, these allegations include charges that AA:

- undermines personal autonomy and responsibility;
- encourages dependence on AA beyond the time that it is needed;
- discourages political activism via a focus on personal rather than social pathology;
- programs members to self-fulfill the prophecy of "one drink, one drunk,"
- coerces particular spiritual/religious beliefs;
- inhibits members from obtaining professional help;
- discourages members from taking needed medications; and
- tolerates exploitive sponsor-sponsee relationships.

Research to-date on iatrogenic effects of recovery mutual-aid involvement is very limited. Studies to-date have found the following:

1) AA and NA members are not discouraged from community participation, and such participation increases with length of sobriety.[356]
2) Some AA members disengage from active participation in AA and NA meetings but sustain long-term abstinence.[357]
3) AA members who continue attending meetings have a lower risk of relapse than those who stop attending.[358]
4) The potential of an "abstinence violation effect" (the idea that members who lapse are more likely to escalate to full-blown relapse because of the "one drink/one drunk" belief among 12-Step groups—the belief that escalation is inevitable because of a unique biological vulnerability over which they have no volitional control) has been theorized by behavioral therapists such as Marlatt,[359] but studies to test this potential have shown mixed results.[360]

---

[355] For examples of anti-AA web sites, see http://www.orange-papers.org/ and http://www.aadeprogramming.org/index_frames.html.

[356] Kurtz, L. & Fisher, M. (2003). Participation in community life by AA and NA members. *Contemporary Drug Problems*, *30*, 875-904.

[357] Godlawski, T.M., Leukefeld, C., & Cloud, R. (1997). Recovery: With and without self-help. *Substance Use and Misuse*, *32*, 621-627. Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

[358] Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1858-1868.

[359] Marlatt, G.A. (1978). Craving for alcohol, loss of control, and relapse: A cognitive behavioral analysis. In P.E. Nathan, G. A. Marlatt, & T. Loberk (Eds.), *Alcoholism: New directions in behavioral research and treatment* (pp. 271-314). New York: Plenum Press.

[360] Birke, S.A., Edelmann, R.J & Davis, P.E. (1990). An analysis of the abstinence violation effect in a sample of illicit drug users. *Addiction*, 85(10), 1299-1307. Ruderman, A.J. & McKirnan, D.J. (1984). Development of a restrained drinking scale: A test of the abstinence violation effect among alcohol users. *Addictive Behaviors*, 9(4), 365-372. Stephens, R.S., Curtin, L., Simpson, E.E., & Roffman, R.A. (1994). Testing the abstinence violation effect construct with marijuana cessation. *Addictive Behaviors*, 19(1), 23-32.

5) AA member use of professional help after joining the organization is high (63% of AA members).[361]
6) AA, as represented by attitudes of its local service representatives, is much more tolerant of medications for the treatment of addiction and co-occurring disorders than has been alleged.[362]

Whether injuries such as those alleged as effects of AA participation occur within recovery support groups—and the types, severity, and relevance of such injuries—are all legitimate and important questions for future scientific investigation. Such studies should compare:

- the potential for injury and variations in types of potential injuries across religious, spiritual, and secular recovery support groups;
- the comparative risk of injury from mutual-aid participation with the risk of injury within professionally directed addiction treatment; and
- the risk of harm in peer and professional interventions compared to the risks faced by persons with substance use disorders who fail to participate in either mutual aid or professional treatment.

POTENT INGREDIENTS OF RECOVERY MUTUAL AID

There is growing evidence that participation in recovery mutual-aid communities enhances long-term recovery outcomes, but the potent ingredients of such participation remain elusive and may differ across individuals at different stages of recovery. The mechanisms of change isolated to-date include:

- problem recognition and commitment to change;[363]
- regular re-motivation to continue change efforts;[364]
- counter-norms that buffer the effects of heavy drinking social networks and AOD use promotion in the wider culture;[365]

---

[361] Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

[362] Alcoholics Anonymous (1984). *The AA member: Medications and other drugs: Report from a group of physicians in AA*. New York: AA World Services. Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., & Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. *Psychiatric Services*, *53*(3), 310-316. Rychtarik, R.G., Connors, G.J., Dermen, K.H., & Stasiewics, P.R. (2000). Alcoholics Anonymous and the use of medications to prevent relapse: An anonymous survey of member attitudes. *Journal of Studies on Alcohol*, *61*, 134-138.

[363] Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, *65*(5), 768-777.

[364] Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, *14*, 376-389.

[365] Emrick, C.D., Lassen, C.L., & Edwards, M.T. (1977). Nonprofessional peers as therapeutic agents. In A.S. Gurman & A.M. Rasin (Eds.), *Effective psychotherapy: A handbook of research* (2nd edition, pp. 120-161). Elmsford: Pergamon.

- sustained self-monitoring;[366]
- increased spiritual orientation;[367]
- enhanced coping skills, particularly the recognition of high-risk situations and stressors;[368]
- increased self-efficacy;[369]
- social support that offsets the influence of pro-drinking social networks;[370]
- helping others with AOD problems;[371]
- exposure to sober role models and experience-based advice on how to stay sober;[372]
- participation in rewarding sober activities;[373]

---

[366] Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, *103*, 387-396.

[367] Galanter, M. (2007). Spirituality and recovery in 12-Step programs: An empirical model. *Journal of Substance Abuse Treatment*, *33*, 265-272. Zemore, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, *100*(4), 447-450.

[368] Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, *21*(1), 54-60. Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, *103*, 387-396.

[369] Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, *65*(5), 768-777. Bogenschutz, M.P., Tonigan, J.S., & Miller, W.R. (2006). Examining the effects of alcoholism typology and AA attendance on self-efficacy as a mechanism of change. *Journal of Studies on Alcohol*, *67*, 562.

[370] Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R.L. (2001). Network support for drinking. In R. Longabaugh & P. W. Wirtz (Eds.), *Project MATCH hypotheses: Results and causal chain analyses* (NIAAA Project MATCH Monograph Series, Vol. 8, NIH Publication No 01-4238; pp. 260-275). Washington: Government Printing Office. Longabaugh, R., Wirtz, P.W., Zweben, A., & Stout, R.L. (1998). Network support for drinking. Alcoholics Anonymous and long-term matching efforts. *Addiction, 93*, 1313-1333. Bond, J., Kaskutas, L. A., & Weisner, C. (2003). The persistent influence of social networks and Alcoholics Anonymous on abstinence. *Journal of Studies on Alcohol*, *64*(4), 579-588. Laudet, A.B., Cleland, C.M., Magura, S., Vogel, H.S., & Knight, E.L. (2004). Social support mediates the effects of dual-focus mutual-aid groups on abstinence from substance use. *American Journal of Community Psychology*, *34*, 175-85. Humphreys, K. & Noke, J. (1997). The influence of post-treatment mutual help group participation on the friendship networks of substance abuse patients. *American Journal of Community Psychology 25*(1), 1-16. Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, *21*(1), 54-60. Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous. *Addiction*, *97*(7), 891-900.

[371] Zemore, S.E., Kaskutas, L.E., & Ammon, L.N. (2004). In 12-Step groups, helping helps the helper. *Addiction*, *99*, 1015-1023. Witbrodt, J. & Kaskutas, L.A. (2005). Does diagnosis matter? Differential effects of 12-Step participation and social networks on abstinence. *The American Journal of Drug and Alcohol Abuse, 31*, 685-707. Zemore, S.E. & Kaskutas, L.A. (2008). 12-Step involvement and peer helping in day hospital and residential programs. *Substance Use and Misuse*, 43, 1882-1903.

[372] Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous, *Addiction*, *97*(7), 891-900.

- 24-hour accessibility of assistance;[374] and
- potentially lifelong supports that do not require financial resources.[375]

ADDITIVE EFFECTS OF PROFESSIONAL TREATMENT AND MUTUAL AID

In studies of clinical populations, completion of addiction treatment *and* participation in recovery mutual-aid groups is more predictive of long-term recovery than either activity alone.[376] There is a potential synergy between AA and treatment. People who attend recovery mutual-aid groups do better following addiction treatment than those who do not attend, regardless of the type of treatment they originally received,[377] and those who participate in treatment and AA are also less likely to drop out of AA than those who only participate in AA.[378] The potential role of recovery support groups and recovery community institutions takes on added significance in light of the present diminished access to treatment and diminished dose of treatment.[379]

---

[373] Moos, R.H. (2008). Active ingredients of substance use-focused self-help groups. *Addiction*, *103*, 387-396.

[374] Kaskutas, L. A., Bond, J., & Humphreys, K. (2002). Social networks as mediators of the effects of Alcoholics Anonymous. *Addiction*, *97*(7), 891-900.

[375] Emrick, C.D., Lassen, C.L., & Edwards, M.T. (1977). Nonprofessional peers as therapeutic agents. In A.S. Gurman & A.M. Rasin (Eds.), *Effective psychotherapy: A handbook of research* (2nd edition, pp. 120-161). Elmsford: Pergamon.

[376] Dawson, D.A., Grant, B.F., Stinson, F.S., & Chou, P.S. (2006). Estimating the effect of help-seeking on achieving recovery from alcohol dependence. *Addiction*, *101*, 824-834. Fiorentine, R. & Hillhouse, M. (2000). Drug treatment and 12-Step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment*, *18*(1), 65-74. Harrison, P.A. & Asche, S.E. (2001). Outcomes monitoring in Minnesota: Treatment implications, practical implications. *Journal of Substance Abuse Treatment*, *21*, 173-183. Kelly, J.F. (2003). Self-help for substance-use disorders: History, effectiveness, knowledge gaps, and research opportunities. *Clinical Psychology Review*, *23*(5), 639-663. Kisson, W., McLeod, C., & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, *26*, 311-323. Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1858-1868. Walsh, D.C., Hingson, R.W., Merrigan, D.M., Levenson, S.M., Cupples, L.A., Heeren, T., et al. (1991). A randomized trial of treatment options for alcohol-abusing workers. *New England Journal of Medicine*, *325*, 775-782.

[377] Tonigan, J.S., Connors, G.J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T.F. Babor & F.K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press.

[378] Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1858-1868.

[379] Laudet, A. & Sands, B. (2007). An exploration of the effect of on-site 12-Step meetings on post-treatment outcomes among polysubstance-dependent clients. *Evaluation Review*, *31*(6), 613-646.

AA can serve as an adjunct or alternative to addiction treatment.[380] Sixty-three percent of AA members received professional help before coming to AA, and 63% received such help after joining AA, leaving 37% of AA members who received no professional support for their recovery before or after their affiliation with AA.[381] In comparison, 76% of people who participate in mental health support groups also receive professional help for the same problems.[382]

TIMING OF PARTICIPATION

Studies by Moos and Moos[383] suggest advantages in linking individuals to recovery support groups prior to linkage to treatment. This allows those who can to resolve AOD problems without the financial and social burden of addiction treatment while enhancing outcomes for those who require professional treatment. In the 16-year treatment follow-up study, those who were exposed to AA prior to treatment had the highest post-treatment recovery rates. Persons who attend recovery support meetings as part of addiction treatment, and who are exposed to 12-Step literature and build 12-Step-related friendships and sponsorship relationships during treatment, are more likely to sustain 12-Step group participation after treatment than are those who are simply referred to support meetings at the end of treatment.[384] Patterns of voluntary recovery mutual-aid participation established by adults during treatment tend to be sustained after treatment.[385]

---

[380] Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, *60*(4), 437-447.

[381] Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

[382] Kessler, R.C., Mickelson, K.D., & Zhoa, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy, 27*, 27-45.

[383] Moos R.H. & Moos B.S. (2004). Help-seeking careers: Connections between participation in professional treatment and Alcoholics Anonymous. *Journal of Substance Abuse Treatment, 26*, 167-173. Moos, R.H. & Moos, B.S. (2006). Participation in treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals. *Journal of Clinical Psychology, 62*(6), 735-750.

[384] Tonigan, J.S., Connors, G.J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T.F. Babor & F.K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press. Kelly, J.F. & Moos, R. (2003). Dropout from 12-Step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment, 24*(3), 241-250. Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1858-1868.

[385] Weiss, R.D., Griffin, M.L., Gallop, R., Onken, L.S., Gastfriend, D.R., Daley, D., et al. (2000). Self-help group attendance and participation among cocaine-dependent patients. *Drug and Alcohol Dependence*, *77*, 177-184. Moos, R.H. & Moos, B.S. (2006). Participation in treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals. *Journal of Clinical Psychology, 62*(6), 735-750.

LINKAGE PROCEDURES AND PARTICIPATION RATES

Studies reveal that as many as 50% of clients who complete primary treatment for substance use disorders do not attend even one recovery support meeting following discharge from treatment.[386] There is a direct relationship between clinician attitudes toward recovery support groups and successful referral rates to such groups, with successful referral rates declining as the clinician's attitudinal resistance towards such groups rises.[387]

Several studies have contrasted procedures of passive linkage to mutual-aid groups (procedures that involve verbal encouragement to attend and provision of a meeting list) with assertive linkage procedures. The latter procedures include orientation to the importance of recovery support group participation; introduction to support group choices and respective philosophies, language, and meeting rituals; encouragement to set goals for group participation; use of a volunteer "guide" to facilitate entry into recovery support group networks and meetings; provision of transportation to early meetings; and use of journaling to monitor responses to meetings.[388] These assertive linkage procedures have been incorporated into manuals that clinicians and recovery support specialists can use as a rigorous introduction to particular recovery mutual aid cultures.[389] Assertive linkage to recovery support groups early in addiction treatment increases post-treatment participation rates for adults [390] and

---

[386] Humphreys, K., Huebsch, P.D., Finney, J.W., & Moos, R.H. (1999). A comparative evaluation of substance abuse treatment: V. Substance abuse treatment can enhance the effectiveness of self-help groups. *Alcoholism: Clinical and Experimental Research*, *233*, 558-63. Laudet, A. & Sands, B. (2007). An exploration of the effect of on-site 12-Step meetings on post-treatment outcomes among polysubstance-dependent clients. *Evaluation Review*, *31*(6), 613-646.

[387] Laudet, A. & White, W. (2005). An exploratory investigation of the association between clinicians' attitudes toward twelve-step groups and referral rates. *Alcoholism Treatment Quarterly*, *23*(1), 31-45.

[388] Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction 101*, 678-688.

[389] See Kaskutas, L.A., Subbaraman, M., Witbrodt, J. & Zemore, S. (in press). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ), a group format 12-step facilitation approach. *Journal of Substance Abuse Treatment*.

[390] Sisson, R.W. & Mallams, J.H. (1981). The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous and Al-Anon meetings. *American Journal of Drug and Alcohol Abuse, 8*, 371-376. McCrady, B.S., Epstein, E.E., & Hirsch, L.S. (1999). Maintaining change after conjoint behavioral alcohol treatment for men: Outcomes at six months. *Addiction*, *94*, 1381-1396. Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction 101*, 678-688. Etheridge, R.M., Craddock, S.G., Hubbard, R.L., & Rounds-Bryant, J.L. (1999). The relationship of counseling and self-help participation to patient outcomes in DATOS. *Drugs and Alcohol Dependence*, *57*, 99-112. Timko, C. & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-Step self-help groups: One-year outcomes. *Drug and Alcohol Dependence*, *90*, 270-279. Walitzer, K.S., Dermen, K.H. & Barrick, C. (2009). Facilitating involvement in Alcoholics Anonymous during out-patient treatment: a randomized clinical

adolescents.[391] Matching individuals to recovery support groups whose philosophies are congruent with their personal beliefs also enhances engagement.[392] At present, most addiction treatment programs do not routinely provide such assertive and individualized linkage procedures.[393]

LINKING ADOLESCENTS TO RECOVERY SUPPORT GROUPS

Problems in linkage between addiction treatment and recovery support groups are particularly pronounced for young people.[394] Adults leaving addiction treatment are twice as likely to attend 12-Step meetings in the first three months than are adolescents discharged from addiction treatment.[395] Studies of adolescents have found several key variables linked to non-affiliation with AA: a drug-using peer social network, a lack of prior treatment, greater parental involvement in treatment, and higher levels of hope.[396] Adolescent affiliation with a recovery support group meeting rises in tandem with the percentage of young people attending.[397] Adolescent affiliation rates and the benefits of participating in recovery support groups can be enhanced by participation in young people's meetings, but these specialty meetings are unavailable in many communities.[398]

Those who have studied linkage of adolescents to recovery support groups note several obstacles. The fact that members of young people's groups "age out" presents a unique problem related to group leadership and stability. Adolescents have also been found to have less problem recognition and motivation for abstinence, less identification with the stories and life issues of

---

trial. *Addiction*, 104, 391-401. Kaskutas, L.A., Subbaraman, M., Witbrodt, J. & Zemore, S. (in press). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ), a group format 12-step facilitation approach. *Journal of Substance Abuse Treatment*.

[391] 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.

[392] Atkins, R.G. & Hawdon, J.E. (2007). Religiosity and participation in mutual-aid support groups for addiction. *Journal of Substance Abuse Treatment, 33*, 321-331.

[393] White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

[394] Kelly, J.F., Myers, M.G., & Brown, S.A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, *14*, 376-389.

[395] 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.

[396] Hohman, L. & LeCroy, C.W. (1996). Predictors of adolescent AA affiliation. *Adolescence*, *31*(122), 339-352.

[397] Kelly, J.F., Myers, M.G., & Brown, S.A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse, 15*, 63-72.

[398] Kelly, J.F., Myers, M.G., & Brown, S.A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse, 15*, 63-72.

older group members, and greater difficulty understanding or utilizing key recovery concepts.[399]

Passetti and Godley[400] studied adolescent treatment center referrals to recovery support groups and found the highest rates of successful linkage within programs that:

- emphasized the sober social activities sponsored by support groups through such events as young people's 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 (e.g., the influence of a sponsor, home group, or step-work) on long-term adolescent recovery outcomes.[401]

EARLY DROP-OUT RATES

Studies reveal that 40-60 % of adult clients who begin participation in 12-Step groups discontinue participation in the 9-12 months following treatment discharge.[402] Studies of post-treatment adolescent participation in 12-Step

---

[399] Lora Passetti, Personal communication, December, 2008.

[400] 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.

[401] Kelly, J.F. & Myers, M.G. (2007). Adolescents' participation in Alcoholics Anonymous and Narcotics Anonymous: Review, implications, and future directions. *Journal of Psychoactive Drugs,* 39, 3, 259-269.

[402] Donovan, D.M. & Wells, E.A. (2007). "Tweaking 12-Step": The potential role of 12-Step self-help group involvement in methamphetamine recovery. *Addiction*, *102*(Suppl. 1), 121-129. Kelly, J.F. & Moos, R. (2003). Dropout from 12-Step self-help groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment, 24*(3), 241-250. Laudet, A. & Sands, B. (2007). An exploration of the effect of on-site 12-Step meetings on post-treatment outcomes among polysubstance-dependent clients. *Evaluation Review*, *31*(6), 613-646. Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1858-1868. Tonigan, J.S., Connors, G.J., & Miller, W.R. (2003). Participation and involvement in Alcoholics Anonymous. In T.F. Babor & F.K. Del Boca (Eds.), *Treatment matching in alcoholism* (pp. 184-204). Cambridge, UK: Cambridge University Press. Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., et al. (2002). AA participation 10 years after Project MATCH treatment: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, *26*(Supplement), 42A.

groups report similar attrition rates.[403] (Attrition rates in non-12-Step groups have not been studied.) The short-term post-treatment outcomes of those who stop attending support meetings, or who attend them only sporadically, descend to the level of outcomes of those who report never regularly attending.[404] This early drop-out rate is not unique to recovery mutual-aid participation and likely parallels attrition in other health improvement and social activities (for example, participation in exercise, dieting, and social clubs).

McIntyre conducted an analysis of the attrition data reported in the membership surveys that AA has conducted since 1968.[405] He draws several conclusions that may apply to the broad spectrum of recovery support groups.

- The most significant period of attrition occurs during the first 90 days of exposure to AA.
- People who sustain participation beyond the first 90 days have significantly increased odds of sobriety 1-5 years later, compared to those who cease participation.
- Reducing or stopping meeting attendance after five years or more of sobriety is common and should not be viewed in the same way as early attrition, since most of those with this later pattern of disengagement remain sober, still consider themselves AA members, and continue to participate in special AA events.

McIntyre's findings on the importance of early engagement in the development of sustained affiliation with AA is confirmed by a 2008 analysis of AA membership survey data. In this study, 26% of AA members in their first month of attendance at AA meetings, and 56% of those in their fourth month, will still be involved in AA at one year.[406] These data reinforce the importance of sustaining early engagement past an initial priming dose—a principle that would also be likely to apply to attendance patterns at other support groups (e.g., Weight Watchers) and health-related activities (e.g., health club participation following enrollment).

A critical point of evaluation for a recovery mutual-aid group is whether the group can attract and sustain the period of involvement needed to make the transition from recovery initiation to stable recovery maintenance. A critical point in the evaluation of P-BRSS is whether linkage procedures to communities of recovery are potent enough to sustain exposure beyond 90 days. We will now explore the dose of participation needed to achieve this transition.

---

[403] Kelly, J.F., Myers, M.G., & Brown, S.A. (2002). Do adolescents affiliate with 12-Step groups? A multivariate process model of effects. *Journal of Studies on Alcohol, 63*, 293-304. Kennedy, B. P. & Minami, M. (1993). The Beech Hill Hospital/Outward bound adolescent chemical dependency treatment program. *Journal of Substance Abuse Treatment, 10*, 395-406.

[404] Kisson, W., McLeod, C., & McKay, J. (2003). The longitudinal relationship between self-help group attendance and course of recovery. *Evaluation and Program Planning*, *26*, 311-23.

[405] McIntyre, D. (2000). How well does A.A.work? An analyses of published A.A. surveys (1968-1996) and related analyses/comments. *Alcoholism Treatment Quarterly*, *18*(4), 1-18.

[406] Arthur S., Tom E. & Glenn C. (2008). Alcoholics Anonymous (AA) recovery outcome rates: Contemporary myth and misinterpretation. Accessed November 24, 2008 at http://hindsfoot.orgt/recount01.pdf.

Dose and Intensity of Participation Effects

Studies of recovery mutual-aid groups reveal evidence of a dose effect (early recovery stability associated with increased meeting attendance)[407] and an intensity effect (recovery stability increasing with broader patterns of participation in such activities as applying concepts to daily problem solving, reading recovery literature, sober socializing, service work).[408]

Frequency of Participation

There are several key findings related to recovery support meeting participation. First, the advisability of initiating recovery via "90 meetings in 90 days" has never been tested scientifically,[409] but this practice does provide intense support through what has been confirmed as the highest period of risk for disengagement and relapse.[410] Second, attending recovery mutual-aid meetings less than an average of once per week, at least during early recovery, is in effect equivalent to not attending meetings.[411] Third, recovery outcomes from a medium level of sustained attendance at support group meetings is equivalent or superior in the long run to the recovery outcomes of those who go from high

---

[407] Chappel, J. N. (1993). Long-term recovery from alcoholism. *Psychiatric Clinics of North America*, *16*(1), 177-187. Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231-238. Kelly, J.F., Stout, R.L., et al, 2006. following intensive outpatient treatment. *Alcoholism: Clinical and Experimental Research, 30*(8), 1381-1392. Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, *32*(8), 1-11.

[408] Cacciola, J.S., Dugosh, K., Foltz, C, Leahy, P., & Stevens, R. (2005). Treatment outcomes: First time versus treatment-experienced clients. *Journal of Substance Abuse Treatment, 28*, S13-S22. Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231-238. Montgomery, H. A., Miller, W. R., & Tonigan, J. S. (1995). Does Alcoholics Anonymous involvement predict treatment outcome? *Journal of Substance Abuse Treatment*, *12*(4), 241-246. Sheeren, M. (1988). The relationship between relapse and involvement in Alcoholics Anonymous. *Journal of Studies on Alcohol*, *49*(1), 104-106. Toumbourou, J.W., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002). Narcotics Anonymous participation and changes in substance use and social support. *Journal of Substance Abuse Treatment*, *23*, 61-66.

[409] Humphreys, K. & Kaskutas, L.A. (2007). *Continuity of care guidelines for participation in mutual help organizations before, during and after addiction treatment*. Presented at the 2nd Consensus Conference of the Betty Ford Institute, October 3-4, 2007.

[410] Hubbard, R. L., Flynn, P. M., Craddock, G., & Fletcher, B. (2001). Relapse after drug abuse treatment. In F. Tims, C. Leukfield, & J. Platt (Eds.), *Relapse and recovery in addictions* (pp. 109-121). New Haven: Yale University Press.

[411] Fiorentine, R. (1999). After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*, *25*(1), 93-116.

initial intensity of participation to low intensity of participation.[412] The latest AA membership survey[413] found that AA members attend an average of 2.4 meetings per week.

Passetti and colleagues looked at thresholds of recovery support group meeting attendance for adolescents in the 90 days prior to their six-month follow-up from addiction treatment. They found a strong link between meeting attendance and six-month abstinence rates. Thirty-nine percent of low attenders (with meetings attended 1-10 days in past three months) reported abstinence, whereas 70% of high attenders (meetings attended 63-90 days in past three months). Unfortunately, the former made up 90% of the sample and the latter only 2% of the sample.[414]

Duration of Participation

Some people require or benefit from lifelong participation in a recovery mutual aid fellowship.[415] In the 2004 AA membership survey, the average length of sobriety reported by members currently attending AA meetings was more than eight years.[416] This finding must be balanced against a growing number of studies documenting that a significant proportion of AA members decrease or stop meeting participation but continue their sobriety and other recovery-related activities.[417] However, those who continue to participate in AA after the first year

---

[412] Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990.

[413] Alcoholics Anonymous (2007). *Alcoholics Anonymous 2007 Membership Survey*. New York: A.A. World Services.

[414] Passettie, L.L., Dennis, M.L., Funk, B.S., Godley, S.H. & Godley, M.G. (2008). Effective thresholds of adolescent self-help meeting attendance and their predictors. Presented at the College on Problems of Drug Dependence, 2008.

[415] Humphreys, K. & Kaskutas, L.A. (2007). *Continuity of care guidelines for participation in mutual help organizations before, during and after addiction treatment*. Presented at the 2nd Consensus Conference of the Betty Ford Institute, October 3-4, 2007.

[416] Arthur S., Tom E. & Glenn C. (2008). Alcoholics Anonymous (AA) recovery outcome rates: Contemporary myth and misinterpretation. Accessed November 24, 2008 at http://hindsfoot.orgt/recount01.pdf.

[417] Tonigan, J.S. (2005). Patterns of AA attendance and drinking over a 10-year follow-up. *Alcoholism: Clinical and Experimental Research*, *29*(Supplement), 381 (Abstract). Hoffmann, H.C. (2003). Recovery careers of people in Alcoholics Anonymous: Moral careers revisited. *Contemporary Drug Problems*, *30*, 647-682. Kaskutas, L.A., Ammon, L.N., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. *Alcoholism: Clinical and Experimental Research, 29*(11), 1983-1990. Tonigan, J. S., Miller, W. R., Chavez, R., Porter, N., Worth, L., Westphal, V., et al. (2002). AA participation 10 years after Project MATCH treatment: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, *26*(Supplement), 42A. Laudet, A., Savage, R., & Mahmood, D. (2002). Pathways to long-term recovery: A preliminary investigation. *Journal of Psychoactive Drugs*, *34*, 305-11. Weiss, R.D., Griffin, M.L., Gallop, R.G., Najavits, L.M., Frank, A., Crits-Christoph, P. et al.

of involvement have better long-term recovery rates than those who do not participate in AA or those who reduce or stop participation after one year of involvement.[418] Kelly and colleagues[419] conducted an 8-year follow-up of adolescents following addiction treatment and found that early AA exposure predicted enhanced long-term outcomes despite declining attendance rates over eight years. As noted, adult studies have found evidence of "nonattending participators," who disengage from meetings but continue to sustain sobriety and other sobriety-related support activities.[420]

ROLE OF INTERNET-BASED RECOVERY SUPPORT[421]

Online recovery support reduces barriers of time, distance, social status, and costs, but it may raise safety concerns for some groups (e.g., adolescents). Web-based recovery support groups (and telephone-based recovery support services) are reaching people who have not participated in face-to-face recovery support meetings, including many:

- adolescents,[422]
- women,[423]
- people with physical disabilities (e.g., people with hearing loss),[424]
- home-bound caregivers,
- status-conscious professionals (e.g., physicians, business executives, judges), [425]

(2005). The effect of self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence, 77*, 177-84.

[418] Moos, R.H. & Moos, B.S. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1858-1868.

[419] Kelly, J.F., Brown, S.A., Abrantes, A., Kahler, C.W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, *32*(8), 1-11.

[420] Weiss, R.D., Griffin, M.L., Gallop, R.G., Najavits, L.M., Frank, A., Crits-Christoph, P. et al. (2005). The effect of self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence, 77*, 177-84.

[421] Kurtz, E. & White, W. (2007). *Telephone- and internet-based recovery support services*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[422] Humphreys, K. & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol, 62*(4), 528-532.

[423] Alemi, F., Mosavel, M., Stpehens, R. et al, (1996). Electronic self-help and support groups. Medical Care, 34(supplement), OS32-OS44. Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*, *24*(2), 161-167.

[424] Cummings, J.N., Sproull, L., & Kiesler, S.B. (2002). Beyond hearing: Where real-world and online support meet. *Group Dynamics: Theory, Research, and Practice*, *6*(1), 78–88.

[425] Skinner, H., Maley, O., Smith, L., Chirrey, S., & Morrison, M. (2001). New frontiers: Using the Internet to engage teens in substance abuse prevention and treatment. In P.M. Monti,

- people in remote locations who have not had the opportunity to participate actively and on an equal basis with people who have higher levels of advantage,[426] and
- non-dependent drinkers.[427]

Online support is also effective for individuals who have made initial progress during primary treatment but prefer an online format of continued recovery support.[428]

Particularly striking is the high percentage of women who use online support groups—a phenomenon likely linked to issues of accessibility, convenience, and safety. Hall and Tidwell's[429] study of those using Internet-based recovery support services reported that women made up more than 60% of those using such services—a dramatically higher percentage than that found in treatment admissions and surveys of face-to-face recovery support groups. (See Table 6 in chapter four.)

From the onset of online support groups, it was assumed that online meetings would supplement face-to-face meetings. Surprisingly, an unknown percentage of individuals are initiating and sustaining recovery online without participation in face-to-face meetings. A day may come in the not-too-distant future when more people participate in online recovery support activities than participate in face-to-face meetings.

Relationship between Helping and Helper Recovery Outcomes

Several studies have concluded that helping others (for example, sponsoring) improves one's own prognosis for recovery.[430] Bohince and

---

S.M. Colby, & T.A. O'Leary (Eds.), *Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions* (pp. 297-318). New York: Guilford.

[426] Chong, J. & Herman-Stahl, M. (2003). Substance abuse treatment outcomes among American Indians in the Telephone Aftercare Project. *Journal of Psychoactive Drugs*, *35*(1), 71-77. Cudney, S. A. & Weinert, C. (2000). Computer-based support groups: Nursing in cyberspace. *Computers in Nursing*, *18*(1), 35-43. Perron, B. (2002). Online support for caregivers of people with a mental illness. *Psychiatric Rehabilitation Journal*, *26*(1), 70-77. Weinert, C., Cudney, S., & Winters, C. (2005). Social support in cyberspace: The next generation. *CIN: Computers, Informatics, Nursing*, *23*(1), 7-15.

[427] Humphreys, K. & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the Moderation Management self-help/mutual aid organization. *Journal of Studies on Alcohol, 62*(4), 528-532.

[428] McKay, J.R., Lynch, K.G., Shepard, 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.

[429] Hall, M. J. & Tidwell, W. C. (2003). Internet recovery for substance abuse and alcoholism: An exploratory study of service users. *Journal of Substance Abuse Treatment*. *24*(2), 161-167.

[430] Cross, G.M., Morgan, C.W., Mooney, A.J., Martin, C.A. & Rafter, J.A. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism: Clinical and Experimental Research*,

Orensteen (1953)[431] conducted one of the earliest studies of AA by comparing those who were successful and those who were unsuccessful in achieving stable recovery in AA. They found that 66% of successful AA members had sponsored other AA members, whereas only 19% of unsuccessful AA members had served as sponsors. Cross and colleagues[432] conducted a follow-up study of inpatient alcoholism treatment and found that those former patients who served as AA sponsors had a 91% recovery rate. In the only study that has been conducted on the effects of sponsorship on inner-city injection drug use, Crape and colleagues[433] found that sponsoring others significantly elevated recovery rates for injection drug users. Witbrodt and Kaskutas[434] studied individuals with alcohol dependence, drug dependence, and alcohol and drug dependence. They found that involvement in peer service work was the best predictor of abstinence across all three diagnostic groups, and that peer helping activities during treatment predicted higher AA involvement after treatment. Also significant is a recent study finding that the benefits of helping within AA cross boundaries of gender, race, education, marital status, employment status, and past level of problem severity. Remarkably, this study also found that AA members with higher levels of depression were more likely to be involved in helping activities and that depressive symptoms lessoned as a result of helping others.[435]

STUDIES OF FAMILY SUPPORT GROUPS

Research studies on recovery support groups for family members affected by severe AOD problems within the family are limited in number, scope

---

14, 169-173. Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, *16*(3), 321-337. Magura, S., Laudet, A.B., Mahmood, D., Rosenblum, A., Vogel, H.S. & Knight, E.L. (2003). Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors*, *28*, 399-413. Pagano, M.E., Friend, K.B., Tonigan, J.S., & Stout, R.L. (2004). Helping others in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol*, *65*, 766-773. Zemore, S.E., Kaskutas, L.E., & Ammon, L.N. (2004). In 12-Step groups, helping helps the helper. *Addiction*, *99*, 1015-1023.

[431] Bohince,E.A. & Orensteeen, A.C. (1953). Evaluation of the services and programs of the Minneapolis Chapter of Alcoholics Anonymous. *Sociology*, *4*, 181-195.

[432] Cross, G.M., Morgan, C.W., Mooney, A.J., Martin, C.A. & Rafter, J.A. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism: Clinical and Experimental Research*, *14*, 169-173.

[433] Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-Step treatment of injection drug users. *Drug and Alcohol Dependence*, *65*, 291-301.

[434] Witbrodt, J. & Kaskutas, L.A. (2005). Does diagnosis matter? Differential effects of 12-Step participation and social networks on abstinence. *The American Journal of Drug and Alcohol Abuse, 31*, 685-707.

[435] Pagano, M.E., Zemore, S, Onder, C.C & Stout, R.L. (2009). Predictors of initial AA-related helping: Findings from Project MATCH*, Journal of Studies on Alcohol and Drugs*, 70, 117-125.

and methodological rigor. Most of what can be concluded about participation in such groups is limited to a small number of studies of Al-Anon and Alateen.

Information on Al-Anon and Alateen members is available from membership surveys that have been conducted since 1984. Table 9 contrasts Al-Anon membership characteristics in 1984 with those measured in 2006.

Table 9: Al-Anon Membership Characteristics in the United States, 1984 and 2006.

Al-Anon Membership Characteristic	1984	2006
% female	88%	85%
Average age	43.6	55
% of members who are Caucasian	96%	87% (7% Hispanic)
% with some college education	49%	80%
% urban and suburban	78%	82%
% referred to Al-Anon by a professional	35%	36%
% receiving professional help before joining Al-Anon	45%	60%
% receiving professional help after joining Al-Anon	44%	58%
Average duration of Al-Anon membership		11.3 years
% of members who left and returned to Al-Anon		41%
Average number of meetings attended per month		7*

* 5% of Al-Anon members participate in online meetings—an average of two online meetings per week.

Compared to members surveyed in 1986,[436] Al-Anon members in 2006 are older and better educated, with a higher representation of women of color and a membership that is more likely to have sought professional help before and after coming to Al-Anon.

Profile information is also available for Alateen members. Members are an average of 14 years of age, predominately female (65%), and more ethnically diverse than members of other 12-Step fellowships (72% Caucasian, 13% Hispanic, 5% Native American, 3% African American and 1% Asian, 12% "mixed" or "other"). Only 8% of Alateen members are referred to Alateen by professional helpers, although 34% sought professional help before coming to Alateen and

[436] 1986 data from Cermak, T.L. (1989). Al-Anon and recovery. *Recent Developments in Alcoholism*, 7, 91-104; Al-Anon Family Group Headquarters (2007). Membership Survey Results: Al-Anon Family Groups, 2006. Retrieved January 16, 2009 at: http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf

.

74% sought help after coming to Alateen. Alateen members attend an average of four Alateen meetings per month and have an average duration of participation of 2.4 years.[437]

Participation in family support groups in the addictions arena might be evaluated on a number of key dimensions, including effects of participation on: 1) understanding of and attitudes toward AOD problems, 2) physical and emotional health, 3) the marital/intimate relationship, 4) the health and functioning of children in the participant's family, 4) measures of family health (e.g., roles, rules, rituals), and 5) effects on help-seeking and recovery outcomes of the family member with an AOD problem. Regarding the last of these dimensions, it should be noted that the primary purpose of family recovery support groups is not to get the addicted family member into treatment or otherwise support the addicted family member's recovery. The primary focus of these groups is on enhancing the emotional health of members and the health of their families. Only 1% of Al-Anon members perceive the primary purpose of Al-Anon as being support of the alcoholic,[438] in spite of the fact that a focus of Al-Anon evaluation studies has been on its effects on the alcoholic family member.

Studies of the effects of family group participation have until recently been only descriptive in nature.[439]

Studies to-date have drawn the following conclusions:

- Al-Anon attracts a diverse mix of family members, spouses, ex-spouses, and friends whose significant others include persons in stable recovery and persons who are actively drinking. [440]
- The self-esteem and marital adjustment of Al-Anon members improve with length of Al-Anon participation,[441] but improvements in marital adjustment, when they occur, are linked to prolonged Al-Anon participation and the spouse's sobriety and level of participation in AA.[442]
- Some studies reveal that the levels of family distress of AA members whose spouses attend Al-Anon do not differ from such levels in the families of AA members whose spouses do not attend Al-Anon, while

---

[437] Al-Anon Family Group Headquarters (2007). Membership Survey Results: Al-Anon Family Groups, 2006. Retrieved January 16, 2009 at: http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf

[438] Al-Anon Family Group Headquarters (2007). Membership Survey Results: Al-Anon Family Groups, 2006. Retrieved January 16, 2009 at: http://www.al-anon.alateen.org/pdf/AlAnonProfessionals.pdf

[439] Cermak, T.L. (1989). Al-Anon and recovery. *Recent Developments in Alcoholism*, 7, 91-104.

[440] Cutler, C.G. & Cutter, H.S. (1987). Experience and change in Al-Anon Family Groups: Adult children of alcoholics. *Journal of Studies on Alcohol*, 33, 1144-1146. Keinz, L.A., Schwartz, C., Trench, B.M. & Houlihan, D.D. (1995). An assessment of membership benefits in the Al-Anon program. *Alcoholism Treatment Quarterly*, 12(4), 31-38.

[441] Keinz, L.A., Schwartz, C., Trench, B.M. & Houlihan, D.D. (1995). An assessment of membership benefits in the Al-Anon program. *Alcoholism Treatment Quarterly*, 12(4), 31-38.

[442] Corenblum, B. & Fischer, D. (1975). Some correlates of Al-Anon group membership. *Journal of Studies on Alcohol*, 36, 65-73.

other studies find that family distress scores decline with extended participation in Al-Anon.[443]

- Participation in Adult Children of Alcoholics support groups engenders substantial changes in members' views of themselves and their families—changes linked to destigmatization of personal experience and increased self-acceptance and self-esteem.[444]
- In early studies of Al-Anon, Al-Anon participation was associated with the spouses of Al-Anon members achieving and sustaining sobriety.[445]
- In more scientifically rigorous studies, "Al-Anon has repeatedly been shown to be ineffective as a unilateral approach for engaging drinkers in treatment."[446]
- Sisson and Azrin compared two approaches to using family members to initiate and support treatment of people with drinking problems: 1) education about the disease of alcoholism with a firm referral to Al-Anon; and 2) Community Reinforcement and Family Training, a program that included education and training on how wives could motivate drinkers to change their behavior via encouragement, consequences, scheduling competing activities, and management of drinking behavior and dangerous situations. None of the husbands in the education/Al-anon group sought treatment, while 86% of the husbands of CRAFT participants entered treatment.[447]
- Miller and colleagues conducted a study of treatment engagement rates comparing Al-Anon participation, the Johnson Institute intervention technique, and the CRAFT model; the resulting treatment engagement rates were 13% for Al-Anon, 23% for the Johnson Institute intervention, and 64% for CRAFT.[448]
- Meyers and colleagues compared three methods of engaging unmotivated drug users in treatment and found treatment engagement

---

[443] McBride, J.L. (1991). Assessing the Al-Anon component of Alcoholics Anonymous. *Alcoholism Treatment Quarterly*, 8(4), 57-65.

[444] Cutter, C.G. & Cutter, H.S. (1987). Experience and change in Al-Anon Family Groups: Adult children of alcoholics. *Journal of Studies on Alcohol*, 33, 1144-1146. Humphreys, K. (1996). World view change in Adult Children of Alcoholics/Al-Anon self-help groups: Reconstructing the alcoholic family. *International Journal of Group Psychotherapy*, 46(2), 255-263. Kingree, J.B. (2000). Predictors and by-products of participation in a mutual help group for adult children of alcoholics. *Alcoholism Treatment Quarterly*, 18(2), 83-94.

[445] Bailey, M. (1965). Al-Anon family groups as an aid to wives of alcoholics. *Social Work*, 10, 68-74.

[446] Fernandez, A.C., Begley, E.A. & Marlatt, G.A. (2006). Family and peer interventions for adults: Past approaches and future directions. *Psychology of Addictive Behaviors*, 20(2), 207-213.

[447] Sisson, R.W. & Azrin, N.H. (1986). Family-member involvement to initiate and promote treatment of problem drinkers. *Journal of Behavioral Therapy & Experimental Psychology*, 17(1), 15-21.

[448] Miller, W.R., Meyers, R.J. & Tonigan, J.S. (1999). Engaging the unmotivated in treatment for alcohol problems: A comparison of three strategies for intervention through family members. *Journal of Consulting and Clinical Psychology*, 67, 688-697.

rates of 29% for Al-Anon/Nar-Anon-facilitation therapy, 58.6% for CRAFT, and 76.7% for CRAFT plus aftercare (up to six months of group sessions following individual sessions).[449]

- Alateen members are more likely than teenagers not in Alateen to view alcoholism as a medical rather than moral problem, to view recovery as possible through participation in support groups, and to believe that children were not responsible for their parents' heavy drinking.[450]
- Alateen members with an alcoholic parent report fewer negative moods, higher self-esteem, and less criminal justice involvement than teens in the same circumstances who do not participate in Alateen; Teens who participate in Alateen have levels of self-esteem and mood comparable to those of teens without an alcoholic parent.[451]

In summary, participation in family recovery support groups enhances participants' understanding of addiction and hope for recovery, enhances their emotional health, and enhances family functioning following sustained duration of participation. Participation in these groups is not the most effective means of engaging unmotivated family members to seek addiction treatment.

In the next chapter, we will explore the effects of participation in other recovery support institutions.

[449] Meyers, R.J., Miller, W.R., Smith, J.E. & Tonigan, J.S. (2002). A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology*, 70, 1182-1185.

[450] Weber, J.A. & McCormick, P. (1992). Alateen members' and non-members' understanding of alcoholism. *Journal of Alcohol & Drug Education*, 37(3), 74-84.

[451] Hughes, J.M. (1977). Adolescent children of alcoholic parents and the relationship of Alateen to these children. *Journal of Counseling and Clinical Psychology*, 45(5), 946-947.

Chapter Five

Scientific Evaluation of Peer-based Services: Studies of the Effects of Participation in other Recovery Community Institutions

SUMMARY OF KEY FINDINGS

- 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.

From temperance hotels to recovery homes, and from the Drunkard's Club to AA Clubhouses and new recovery community centers, recovery support structures organized by and for recovering people have long played a role in addiction recovery in the United States. Surprisingly, the nature of this influence has been subjected to only limited scientific study. Two recent articles[452] highlight the recent growth of recovery community institutions: recovery

[452] Valentine, P., White, W., & Taylor, P. (2007). The recovery community organization: Toward a definition. Retrieved from http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf. White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

community organizations, recovery homes, recovery industries, recovery schools, recovery ministries and recovery churches, religious recovery colonies, recovery cafes, recovery book clubs, and recovery athletic teams, as well as a resurgence in recovery-focused consumer councils, alumni associations, and volunteer programs linked to addiction treatment institutions.

The presence and scope of these recovery support institutions are rarely acknowledged in the scientific literature and even more rarely evaluated with methodological rigor. Here is what we know to-date.

Recovery Social Clubs

Considering the large number of studies conducted on recovery mutual aid meetings, it is surprising how little attention has been given to studying the effects of mutual-aid society clubhouses on recovery initiation and maintenance. A few studies are indicative of the potential of these recovery support institutions.

Hunt and Azrin[453] described a self-governed social club for recovering alcoholics that was part of a more comprehensive community reinforcement approach (CRA) to alcoholism treatment. Those who participated in this CRA approach achieved superior outcomes as measured by decreased alcohol consumption, increased employment, and decreased hospitalization compared to matched control group members, but the role of the social club was not isolated for analysis. Two subsequent studies clarified this relationship. Mallams and Hall[454] found that the social club reduced relapse rates, reduced treatment re-admission, and enhanced global functioning. Mallams, Godley, Hall, and Myers[455] confirmed these effects and illuminated strategies for involving clients in the activities of the social club. They found that traditional referral procedures (providing each client with written information on the club and providing a single verbal statement of encouragement to attend) had little effect on initiating or sustaining club involvement. In contrast, systematic encouragement procedures significantly increased club participation. The procedures included an average of ten personal statements of encouragement to attend, letters sent describing scheduled club activities, provision of membership cards and club by-laws, resolving obstacles to participation, a warm welcome and praise from other members for attending, and assessing and providing preferred recreational activities at the club.

One clubhouse for adolescents exists in Kentucky as part of the Louisville Adolescent Network of Substance Abuse Treatment (LANSAT). According to their website (www.sevencounties.org), the youth clubhouse was designed to complement and expand an array of existing services by offering structured

---

[453] Hunt, G.M. & Azrin, M.H. (1966). A community-reinforcement approach to alcoholism. *Behavior Research and Therapy*, *11*, 91-104.

[454] Mallams, J.H. & Hall, G.M. (1975). *An experimental social club for alcoholics and their families: A two year follow-up study.* Presented at the meeting of the Illinois Alcoholism and Drug Dependence Association, December.

[455] Mallams, J.H., Godley, M.D., Hall, G.M., & Myers, R.J. (1982). A social systems approach to resocializing alcoholics in the community. *Journal of Studies on Alcohol, 43*, 1115-1173.

programming, recreational, and socialization opportunities in a drug-free and recovery-focused environment. The clubhouse is accessible to adolescents who have a desire to participate in activities and groups and are interested in decreasing use and/or maintaining sobriety. Adolescents may be in treatment, have completed treatment, or be affected by the use of family members. Structured groups offered include recovery support groups, skill development groups, special interest groups, and 12-Step meetings. Recreational activities include game night, basketball, shooting pool, and playing ping-pong. Tutoring and informal SAT/ACT assistance are also offered.[456]

Recovery Community Centers

Many recovery community organizations are establishing recovery community centers as a central recovery "hub," gathering place, and peer-based service center for people seeking or in recovery, and for their family members. These centers serve a clubhouse function in terms of recovery fellowship, but offer a much wider spectrum of recovery support services than would be available in a typical AA clubhouse. They also serve as an organizing place for recovery advocacy activities. The number of centers is growing rapidly, particularly in the Northeastern United States. For example, there are networks of recovery community centers in Connecticut, Pennsylvania, Vermont, New York, and New Hampshire. (See program profiles below.) The organizations that run these centers conduct their own internal evaluations, but no studies have been published on their effects on recovery initiation/maintenance; quality of life in recovery; or societal attitudes toward people in and/or seeking recovery, or toward their families.

[456] Lora Passetti, Personal communication, December, 2008.

Program Profile 13: Vermont Recovery Center Network (VRCN)[457]
Purpose: Provide a venue for sober socializing, peer recovery support, recovery-focused community education, and recovery advocacy activities
Service Elements: Social support and fellowship; recovery support group meetings; recovery education and training; linkage to needed services; social activities; recovery advocacy.
Service Volume/Status: Currently nine recovery community centers across Vermont; approximately 70 hours per week of operation; supported primarily by 15 part-time staff and 150 volunteers (30,000 hours of volunteer support per year); 127 recovery support meetings per week held across nine centers; 143,903 visits to the nine centers in past year; 25% of visitors have less than a year of sobriety since completing treatment; 33% of visitors have never been in treatment; 20% of visitors are on probation or parole; current funding level is $47,000 per center per year.
Service Outcomes: 50% of participants acknowledge VRCN role in recovery initiation; 88% acknowledge VRCN role in recovery maintenance; the employment of visitors to the centers increased from 36% at initial contact to 50% at follow-up; reported homelessness decreased from 25% at initial visit to 12.5% at follow-up.
Service Lessons: 1) Recovery centers (RCs) must be wanted and driven by recovery community; 2) where RCs failed in VT, they did so due to lack of perceived need and lack of grassroots organizing that preceded their opening; 3) importance of idea of RC without walls—an RC that organizes events using available community facilities rather than a designated building; 4) importance of moving RC beyond creation of a 12-Step clubhouse; 5) importance of funding diversification to enhance sustainability.
For More Information: Contact Patty McCarthy at RecoveryVT@aol.com and Mark Ames at vtrecoverynetwork@gmail.com.

[457] Personal communication with Patty McCarthy, Executive Director, Friends of Recovery Vermont; additional information 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.

Program Profile 14: Philadelphia Recovery Community Center[458]
Purpose: A collaborative effort between the Philadelphia Office of Addiction Services and PRO-ACT to provide a venue for the delivery of peer-based recovery support services (opened December, 2007).
Service Elements: 1) Life-skills education; 2) recovery coaching; 3) recovery plan development; 4) educational/employment coaching; 5) family support and relationship enhancement; 6) parenting training; 7) special interest support groups; 8) sober leisure; and 9) community service projects.
Service Volume/Status: In first eleven months of operation, the Recovery Community Center had 3279 visitors, provided 161 workshops and 21 other skill-building opportunities to 793 individuals, trained 61 volunteers who contributed more than 2,451 hours to the Center, and made 206 referrals to addiction treatment programs.
Service Outcomes: 6-month follow ups indicated that in the employment/education category a 41.7 % increase occurred in employment and/or school attendance; those reporting stable living environments increased from 23.1% at intake to 46.2 % (reporting a permanent place to live) at 6-month follow up; 100% reported no crime or involvement with the criminal justice system within the past 30 days; and 100% reported that they believed they were socially connected.
Service Lessons: 1) Importance of conveying history and tenets of recovery movement—making people feel a part of something larger than themselves; 2) importance of conveying that everyone has something to give as well as receive from recovery center participation; 3) need to re-emphasize continually that the center is a place for fellowship and community, rather than therapy; 4) importance of stage-appropriate activities that "set people up for success," with success contingent upon skills and support; 5) importance of wide mix of activities to appeal to diverse needs of recovery community members; 6) creating a safe place for people to acknowledge a lapse/relapse episode speeds re-initiation of recovery stability; 7) a source of personal shame (e.g. prison) can be transformed into an asset that can be used to help others.
For More Information: Contact Bev Haberle at bhaberle@bccadd.org or 215-262-5771

RECOVERY HOMES

Recovery homes were founded on the proposition (and growing evidence) that sobriety-supportive living environments can elevate recovery outcomes.[459] There is a long history of residential therapies and halfway and

[458] Personal communication with Bev Haberle, December, 2008

[459] Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*, *20*(4), 427-441. Jason, L., Davis, M., Ferrari, J., & Bishop, P. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education 31*(1), 1-27. King, M. P. & Tucker, J. A. (2000). Behavior change patterns and strategies distinguishing moderation drinking and abstinence during the natural resolution of alcohol problems without

three-quarter-way houses, all fueling the modern recovery home movement.[460] Residents in these facilities are expected to work, pay their rent, and provide each other mutual support within an environment that may or may not include professional-directed treatment services.

Today, the term "recovery home" is used loosely—too loosely—to describe a continuum of recovery-focused housing services that range from staff-directed residences that in earlier periods were referred to as halfway and three-quarter way houses to self-managed residences of recovering people. The latter constitute hidden resources that exist in a growing number of communities. A recent survey of such homes in Philadelphia showed 25 recovery homes receiving financial support from the Department of Behavioral Health, while another 250 such homes were financially self-supported by their residents.[461] The same survey revealed wide variation in quality of the physical facilities, depth of recovery orientation, and degree of connection to the local community.

The predominant recovery home model is Oxford House. Founded in 1975, Oxford House has grown to include more than 1,200 recovery homes occupied by more than 24,000 recovering people a year in 48 states.[462] The Oxford Houses are multiple-bedroom dwellings segregated by gender and located in stable neighborhoods judged to be conducive to recovery. Nearly 200 of the homes are for women, and 34 are designed specifically for women and children.[463]

The Oxford House model has several distinctive features:

- democratic self-governance,
- financial self-support of each home by its members,
- shared house chores,
- reliance on support from peers rather than paid staff,
- no required exclusive pathway of recovery (e.g., no mandated treatment participation or AA attendance),
- self-determined lengths of stay,
- an expectation of complete and enduring abstinence, and
- the expulsion of anyone who uses alcohol or drugs.[464]

---

treatment. *Psychology of Addictive Behaviors*, *14*(1), 48-55.

[460] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

[461] Johnson, R., Martin, N., Sheahan, T., Way, F., & White, W. (2008). *Recovery resource mapping: Results of a Philadelphia recovery home survey*. Philadelphia: Department of Behavioral Health and Mental Retardation Services.

[462] Molloy, P. & White, W. (in press). Oxford Houses: Support for recovery without relapse. *Counselor*. Oxford House (2006). *Oxford House comes of age: Oxford House—The model*. Presented at the 8th Oxford House World Convention, Wichita, KS, September 21-24, 2006.

[463] d'Arlach, L., Olson, B.D., Jason, L.A., & Ferrari, J.R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, *31*(1/2), 121-131.

[464] Ferrari, J.R., Jason, L.A., Davis, M.I, Olson, B.D., & Alvarez, J. (2004). Similarities and differences in governance in drug and/or alcohol misuse recovery: Self vs. staff rules and regulations. *Therapeutic Communities*, *25*(3), 185-198. Jason, L.A., Davis, M.I., Ferrari, J.R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education, 31*(1), 1-27.

The Oxford Houses provide residents considerably more personal liberties (e.g., the ability to bring personal belongings, personal choice of daily schedule, freedom to leave for weekends, and "private time" with guests in their rooms) than would be found in most residential treatment settings or therapeutic communities.[465]

Leonard Jason and his colleagues at DePaul University's Center for Community Research have evaluated this model extensively. Major findings from their studies include the following.

- 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 those of addiction treatment populations.[466]
- Alcoholics Anonymous is the dominant framework of recovery for Oxford House residents (76%), but other pathways of recovery are also respected (with 17% reporting individual psychotherapy as their primary recovery support medium).[467]
- At 2-year follow-up, residents who stayed in an Oxford House for a minimum of six months following residential addiction treatment had superior recovery outcomes compared to those placed in traditional aftercare and had higher rates of employment, higher incomes, and significantly lower rates of arrest.[468]
- The prospects of long-term recovery rise with length of stay in an Oxford House.[469]
- At extended follow-up, 69% of residents continue to live in the house or have left as planned and in good standing.[470]

Jason, L.A., Olson, B.D., Ferrari, J.R., Layne, A., Davis, M.I., & Alvarez, J. (2003). A case study of self-governance in a drug abuse recovery home. *North American Journal of Psychology*, *5*(3/4), 1-16.

[465] Ferrari, J.R., Jason, L.A., Davis, M.I, Olson, B.D., & Alvarez, J. (2004). Similarities and differences in governance in drug and/or alcohol misuse recovery: Self vs. staff rules and regulations. *Therapeutic Communities*, *25*(3), 185-198.

[466] Ferrari, J.R., Curtin-Davis, M., Dvorchak, P., & Jason, L. (1997). Recovering from alcoholism in communal living settings: Exploring the characteristics of African American men and women. *Journal of Substance Abuse*, *9*, 77-87. Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*, *32*, 803-818.

[467] Nealon-Woods, M.A., Ferrari, J.R., & Jason, L.A. (1995). Twelve-step program use among Oxford House residents: Spirituality or social support in sobriety? *Journal of Substance Abuse*, *7*, 311-318.

[468] Jason, L.A., Olson, B.D., Ferrari, J.R., Majer, J.M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, *102*, 1114-1121. Jason, L. A., Olson, B. D., Farrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health, 96*, 1727-1729.

[469] Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*, *32*, 803-818.

[470] Majer, J., Jason, L. Ferrari, F.R., & North, C. (2002). Co-morbidity among Oxford House residents: A preliminary outcome study. *Addictive Behaviors*, *27*, 837-845.

- Women's Oxford Houses that accommodate children have a positive effect both on the mothers and on the other women in the house.[471]
- The communal environment of the Oxford House has been found to be particularly congruent among African American men and women and members of other groups whose historical experience has created a distrust of authority figures.[472]
- Psychiatric severity does not constitute an impediment to successful recovery within Oxford House.[473]
- Community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses.[474]

Recovery within the Oxford Houses has been conceptualized as the transition from a destructive dependency on drugs to a constructive dependency on recovery peers.[475]

Two system-wide efforts to map and/or organize recovery homes are described in Program Profiles 15 and 16:

[471] d'Arlach, L., Olson, B.D., Jason, L.A., & Ferrari, J.R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, *31*(1/2), 121-131.

[472] d'Arlach, L., Olson, B.D., Jason, L.A., & Ferrari, J.R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, *31*(1/2), 121-131. Ferrari, J.R., Curtin-Davis, M., Dvorchak, P., & Jason, L. (1997). Recovering from alcoholism in communal living settings: Exploring the characteristics of African American men and women. *Journal of Substance Abuse*, *9*, 77-87.

[473] Majer, J.M., Jason, L.A., North, C.S., Ferrari, J.R., Porter, N.S., Olson, B., Davis, M., Asse, D. & Molloy, P. (2008). A longitudinal analysis of psychiatric severity upon outcomes among substance abusers residing in self-help settings. *American Journal of Community Psychology,* 42(102), 145-153.

[474] Jason, L.A., Roberts, K., & Olson, B.D. (2005). Attitudes towards recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology, 33*(5), 529-535.

[475] Nealon-Woods, M.A., Ferrari, J.R., & Jason, L.A. (1995). Twelve-step program use among Oxford House residents: Spirituality or social support in sobriety? *Journal of Substance Abuse*, *7*, 311-318.

Program Profile 15: Recovery Home Survey (Philadelphia, PA)[476]
Purpose: 1) To map the number and location of recovery homes and other recovery support services in the city of Philadelphia, 2) to compare the depth and zip code location of recovery support services to areas of greatest need as revealed by zip code analysis of AOD problem indicator data.
Service Elements: Site visits were conducted at all identified recovery homes in the City of Philadelphia; each recovery home was rated on physical plant, recovery programming, and community involvement; recovery home survey data were compared to other recovery resource and AOD problem indicator data by Philadelphia zip code.
Survey Outcomes: 1) 22 funded and 267 unfunded recovery homes were identified; 2) funded homes rated considerably higher in quality than unfunded homes; 3) zip codes were identified as having high problem severity and low recovery capital, and these zip codes can be targeted for future recovery resource development.
Service Lessons: 1) "You can't judge a book by its cover": Some very attractive homes have little recovery programming, while some unattractive homes have vibrant recovery cultures; 2) Recovery home surveys can weed out boarding houses (with active drinking) that misrepresent themselves as recovery homes; 3) It is possible to analyze AOD problems and recovery resources by zip codes within a community.
For More Information: Contact Fred Way at FWay@pmhcc.org or 215-790-4973

Program Profile 16: Connecticut Community of Addiction Recovery's Recovery Housing Project
Purpose: 1) Establish a state-of-the-art database of all recovery houses www.findrecoveryhousing.com in Connecticut; 2) organize interested recovery home owners to form the statewide Recovery Housing Coalition of Connecticut; 3) establish minimum standards to open and operate recovery homes via the Recovery Housing Coalition of Connecticut, to ensure good-quality housing for people in recovery; and 4) provide training to potential owners on how to establish a recovery home.
Service Elements: Recovery House owners were invited to participate in the Recovery Housing Coalition of Connecticut, which developed a set of standards that they believed would "set the bar high," ensuring that recovery housing in CT was safe and affordable. Site visits were conducted at all identified recovery homes in CT; each owner was asked to agree to the standards set forth. www.findrecoveryhousing.com was launched, with more than 80 houses listed. Referrals to Recovery Houses continue at about 100 per week.

[476] Johnson, R., Martin, N., Sheahan, T., Way, F. & White, W. (2008). Recovery Resource Mapping: Results of a Philadelphia Recovery Home Survey. Philadelphia Department of Behavioral Health and Mental Retardation Services.

Connecticut Community of Addiction Recovery's Recovery Housing Project (Continued)
Survey Outcomes: 1) Identified more than 170 houses, of which 80 are currently listed on www.findrecoveryhousing.com; 2) conducted site visits and surveys at each Recovery House (the other 80 are currently being contacted); 2) saw more than 30 new homes established as a result of the "So, You want to Open a Recovery House" Training; 3) held monthly meetings of Recovery Housing Coalition of CT and began updating its standards; 4) provided linkage between recovery home owners and state agencies, to enhance referrals and the quality of recovery housing.
Service Lessons: 1) www.findrecoveryhousing.com allows owners to update their bed availability, but it has been a challenge to persuade them to do it themselves; 2) there continues to be a huge need for safe, affordable, funded recovery homes; 3) Recovery Housing Coalition of CT has become a group of very passionate owners who want to ensure the quality of recovery housing in CT.
For More Information: Contact Cheryle Pacapelli at cheryle@ccar.us or 860-244-2227

When local recovery community organizations (RCOs) conduct focus groups to assess the needs of the recovery community, recovery-supportive housing is always near the top of the priority lists that are generated. As a result, many RCOs are developing or encouraging the development of self-governed, self-supported recovery homes. They are also finding creative ways to link people in need to these homes. (See findrecoveryhousing.org.)

Recovery Colonies

Recovery colonies—whole communities made up of recovering people—have a history that dates to the late nineteenth century. At that time, it was discovered that alcoholics who initiated recovery through the Christian rescue missions in urban America were in need of a setting for more extended healing. Religion-sponsored recovery colonies such as Keswick Colony of Mercy, founded in 1897, grew in response to this need.[477] Here is a brief account based on the author's visits to a recovery colony.

> In 1962, Mickey and Laura Evans had a vision and a calling to build a camp for recovering alcoholics in the South Florida wilderness. That vision turned into Dunklin Memorial Camp, which has for more than 45 years served individuals and families wounded by alcohol and other drugs. The first striking characteristic of Dunklin is its remoteness. The question, "Are we lost?" is common on first and subsequent journeys to the area. As one enters Dunklin, what one finds is a self-contained and self-sufficient community. Driving through the community, one passes

[477] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

multiple dormitories, homes for staff, homes for resident families and families who visit on weekends, a mess hall, a tabernacle, a school, a computer lab, a library, a lumber mill and furniture workshop, hog and cattle pens, fruit groves and sugar cane fields, a health clinic, rodeo grounds, and a cemetery. Effusive love connects the members of this community. Work crews circle in prayer before beginning work in the various industries; hugs abound as the community enters the mess hall for lunch, and prayers precede each meal—real prayers, personal prayers, rather than those memorized and delivered in rote. This is not a treatment center; it is a healing community. From its humble beginnings, the Dunklin vision has expanded to encompass a larger vision of residential recovery, family recovery, ministry training, and the development of new cities of refuge (Dunklin-type communities around the world) and outreach through jail and prison ministries and Overcomers Groups in local communities. That vision has already extended Dunklin's work across the Southeastern United States and Costa Rica, and into South America. Dunklin Memorial Camp is part of the growing network of addiction recovery colonies in the United States.

A secular variant of the religious recovery colony can be found in efforts to create recovery villages (for example, as units within public housing projects or specialty programs within shelters) where recovering individuals and their families can sustain themselves in a recovery-conducive physical and social environment.[478]

Recovery colonies are all but invisible to the public, and the mainstream addiction treatment field and the research community seem to be completely unaware of their existence.

Recovery Schools[479]

Recovery high schools have saved my life.

—Stefanie K., Recovery High School Student [480]

One of the newest recovery community institutions is the recovery school. This institution provides support for recovering students within what has been

[478] Graham, A. V., Graham, N. R., Sowell, A., & Ziegler, H. (1997). Miracle Village: A recovery community for addicted women and their children in public housing. *Journal of Substance Abuse Treatment*, *14*(1), 275-284. Leaf, P. J., Thompson, K. S., Lam, J. A., Jekel, J. F., Armand, E. T., Evans, A. E., et al. (1993). Partnerships in recovery: Shelter-based services for homeless cocaine abusers. New Haven. *Alcoholism Treatment Quarterly*, *10*(3-4), 77-90.

[479] White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

[480] Finch, A.J. (2007). Authentic voices: Stories from recovery school students. *Journal of Groups in Addiction and Recovery, 2*, 16-37.

described as an "abstinence-hostile environment."[481] Between 1977 and 2000, collegiate recovery school programs were established at Brown University, Rutgers University, Texas Tech University, and Augsburg College. Collegiate recovery programs were established between 2001 and 2004 at Dana College, Grand Valley State University, Case Western Reserve University, University of Texas at Austin, and Loyola College in Maryland. Since Ecole Nouvelle (now Sobriety High) in Minnesota was opened in 1986 as the first recovery high school, the growth of high school programs specifically for recovering students has quickened. Twenty-five recovery high schools opened across the United States between 1999 and 2005. This rapid growth sparked the formation of the Association of Recovery Schools.[482]

Recovery school programs vary in their design, but generally combine special recovery support services, with an emphasis on academic excellence. The former may include special faculty guidance, recovery dorms, recovery support meetings, recovery drop-in centers, sober social activities, and peer mentoring. The latter is achieved through academic guidance, study centers, and peer-tutoring programs. Preliminary studies of these programs confirmed high rates of uninterrupted abstinence (70-80%); early intervention and retention of students following lapse; and excellent academic performance as measured by grades (well above the student average), class attendance rates (90-95%), and the number of students in recovery high schools going on to college (65%).[483]

Gibson[484] conducted a study of a school-based recovery support (RSS) curriculum established in 1986 for Wichita Southeast High School students returning from residential treatment. Students who qualified for RSS but did not enroll were used as a control group. The major findings included 1) an 82% recovery rate for the students enrolled in the RSS, 2) a high rate of school withdrawal for those students who qualified but did not participate in RSS, and 3) significant improvements in school attendance and family relationships for RSS students. Students reported that RSS served as an effective bridge from treatment to recovery and helped address their feelings of anxiety, isolation, and self-consciousness; concerns about making new friends; and academic performance.

---

[481] Cleveland, H.H., Harris, K. S., Baker, A. K, Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment. 33*(1), 13-23.

[482] White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58.

[483] White, W. L. (2001b). Recovery university: The campus as a recovering community. *Student Assistance Journal, 13*(2), 24-26. White, W. & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58.

[484] Gibson, R.L. (1991). *School-based recovery support: The time is now*. Presented at the annual convention of the American Association of Counseling and Development, Reno, Nevada, April 21-24.

Moberg and Finch[485] conducted a study of 18 recovery high schools in six states over the course of three semesters. They found that recovery high schools:

- operate under a variety of names, including *recovery school, sober school, alternative school, charter school,* and *learning center*;
- usually have small enrollments (12-25 students);
- receive financial support primarily through a mix of public and private funding; and
- serve to support recovery maintenance rather than recovery initiation.

Weekly substance use for the students in the Moberg/Finch survey dropped from 90% prior to entrance into a recovery school to 7% at the time of the survey, with 56% of students reporting continuous abstinence since their enrollment in a recovery school. Students in the recovery school survey also reported decreased emotional problems and increased personal progress, particularly academic progress.

Harris and colleagues[486] conducted a study of a campus recovery community at Texas Tech University (TTU). Elements of this program include 1) financial assistance for recovering students entering or returning to college, 2) support from the staff at the Center for the Study of Addiction and Recovery (CSAR), 3) daily on-campus 12-Step meetings, 4) seminars on addiction and recovery, 5) a system of peer mentoring for recovery support and academic coaching, 6) parent and family weekends on campus, and 7) an expectation of community service. They found that students within the Texas Tech collegiate recovery community had a 3.18 grade point average, a 70% graduation rate, and a relapse rate of only 8%. A separate study of the TTU campus recovery community from 2003-2006 confirmed the high level of academic achievement and found a within-semester relapse rate of only 4.4%.[487] This is a striking rate of recovery when one considers the environmental context of this achievement and the fact that more than half of those completing addiction treatment in the United States use alcohol and/or drugs within 12 months post-discharge.[488]

Botzet and colleagues have reported on Augsburg College's StepUP Program. This program included options for drug- and alcohol-free living environments, weekly one-to-one and group recovery support meetings, sobriety contracts, sober social activities, and behavioral requirements that included attending AA/NA and other campus recovery support meetings. They reported outcomes for 46 current students and 37 alumni. Only one student presently

---

[485] Moberg, D.P. & Finch, A.J. (2007). Recovery high schools: A descriptive study of school programs and students. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 128-161.

[486] Harris, K., S. Baker, A.K., Kimball, T.G., & Shumway, S.T. (2007). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 220-237.

[487] Cleveland, H.H., Harris, K. S., Baker, A. K, Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment, 33*(1), 13-23.

[488] White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

enrolled reported substance use in the past six months, and none met criteria for current substance use disorders. Eight (21.6%) former students reported one or more episodes of alcohol or drug use in the previous six months, and only one student surveyed (2.7%) met criteria for a current substance use disorder in the past six months.

> *The overwhelming majority of current StepUP students is not using drugs, is maintaining a favorable GPA, is functioning quite well socially, and perceives the StepUP program as vital to their overall well being*.[489]

PEER-BASED OCCUPATIONAL RECOVERY SUPPORT

Those admitted to addiction treatment have high unemployment rates and a high need for employment counseling,[490] but employment counseling, vocational training, and job-seeking skills training are not standard components of most addiction treatment programs, nor are assertive linkages to these services routine components of specialty-sector addiction treatment[491] There has been an unstated assumption that successful recovery will by itself increase employment, but studies have drawn three conclusions that challenge this assumption: 1) providing standard addiction treatment does not in itself significantly increase post-treatment employment rates,[492] 2) post-treatment employment status is not a predictor of abstinence (suggesting that successful recovery is possible without stable employment),[493] and 3) programs that place greater emphasis on combinations of ancillary services such as sober housing and employment have better recovery outcomes than those that offer strictly clinical interventions.[494]

The importance of establishing financial self-sufficiency is underscored by the finding that recovery outcomes can be compromised by low socio-economic status.[495] To achieve the goal of economic self-sufficiency, new recovery support

---

[489] Botzet, A.M., Winters, K., & Fahnhorst, T. (2007). An exploratory assessment of a college substance abuse recovery program: Augsburg College's StepUP Program. *Journal of Groups in Addiction and Recovery, 2*(2-4), 257-287.

[490] Hser, Y., Polinsky, M. L., Maglione, M., & Anglin, M. D. (1999). Matching clients' needs with drug treatment services. *Journal of Substance Abuse Treatment*, *16*(4), 299-305.

[491] Room, J. (1998). Work and identity in substance abuse recovery. *Journal of Substance Abuse Treatment*, *15*(1), 65-74.

[492] Magura, S. (2003). The role of work in substance dependency treatment: A preliminary overview. *Substance Use and Misuse*, *38*(11-13), 1865-1876.

[493] Reif, S., Horgan, C. M., Ritter, G. A., & Tompkins, C. P. (2004). The impact of employment counseling on substance user treatment participation and outcomes. *Substance Use and Misuse*, *39*(13 & 14), 2391-2004.

[494] Kaskutas, L. A., Ammon, L. N., & Weisner, C. (2004). A naturalistic analysis comparing outcomes of substance abuse treatment programs with different philosophies: Social and clinical model perspectives. *International Journal of Self Help and Self Care*, *2*, 111-133.

[495] McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

organizations such as Recovery at Work in Atlanta are experimenting with recovery work co-ops as a transition from treatment to mainstream employment. These co-ops are small businesses within the recovery community that help people in recovery return to mainstream employment or obtain such employment for the first time. Such services integrate the opportunity for stable employment with disengagement from criminal enterprises, resolution of existing legal problems, participation in community life, and acts of community service. They also attempt to address the discrimination that recovering people, particularly those with addiction-related criminal histories, face in seeking employment.

Program Profile 17: Recovery Oriented Employment Services, Hartford, CT (Connecticut Community of Addiction Recovery)
Purpose: Pilot employment project in which a Recovery Community Organization (RCO) collaborates with local treatment providers in Hartford, Willimantic, and New London, CT to: 1) help people in recovery become active members of their communities; 2) combine treatment, case management, vocational training, and recovery support; and 3) link persons in recovery needing employment with recovery-friendly businesses.
Service Elements: 1) Treatment providers screen clients for employment needs and assist with vocational choices, a vocational plan, and referrals; 2) the RCO provides job readiness training, on-the-job recovery strategies, telephone recovery support, employment-focused support groups, and opportunities for participation in other recovery support services and recovery-focused service activities.
Service Volume/Status: The pilot program in Hartford began in July, 2008; the Willimantic pilot in September, 2008; and the New London program in February, 2009. Between 7/1/08 and 12/31/08, 151 clients had been enrolled, with 21 currently enrolled. 72 participants have obtained employment. Recovery Friendly Business coalition meetings began in December, 2008 and continue on a monthly basis.[496]
Service Lessons: 1) Transportation challenges continue to limit participants' ability to find employment. 2) Community stigma surrounding addiction, gaps in work histories, and arrest records are also major stumbling blocks to employment. 3) Participants rely on support from Recovery Community Center throughout the training and employment process.
For More Information: Contact Diana Desnoyers at diana@ccar.us or 860-218-9476

Initiatives like Recovery at Work and Recovery Oriented Employment Services assume that employment is a support for and an outcome of recovery, but a pilot study by Godley, Passetti, and White suggests that employment plays a more complex role in adolescent recovery from substance use disorders. They found a consistent relationship between days of full-time employment and increased days of AOD use during the six months following discharge from treatment. Possible explanations for this finding include the influence of AOD-

[496] Personal communication with Linda Guillorn, CT Department of Mental Health and Addiction Services, January, 2009.

using colleagues in the workplace, availability of income to purchase alcohol and other drugs, and conflicts between work schedules and recovery support activities.[497] This finding underscores the potential need for recovery-conducive employment opportunities for adolescents and special recovery supports for employed adolescents in recovery.

As noted earlier, occupational recovery support groups also exist, but there is a marked absence of studies evaluating whether participation in these groups as an adjunct or alternative to 12-Step or other recovery support groups elevates long-term recovery outcomes. The exception to this lack of research involves professional peer assistance programs organized for high-status professional groups such as physicians, nurses, attorneys, and airline pilots.[498] The most extensive research has been conducted on the physician health programs (PHPs) that have long provided a peer-based framework for recovery for addicted physicians.

A recent review of available PHP research confirmed the exceptionally high recovery rates of physicians participating in PHPs—70-96% across studies. These exceptional recovery rates were linked to: 1) educational programs that promote early referral; 2) peer-based intervention services; 3) comprehensive evaluations; 4) linkage to abstinence-based, comprehensive treatment; 5) sustained peer-based support; and 6) long-term monitoring (for at least five years).[499] Those of us involved in this review of PHPs left that experience wondering why all Americans did not have access to such key service elements. The fact that the highest recovery rates in the scientific literature include sustained support and strong peer-based recovery components deserves broader attention from the providers of treatment and recovery support systems and their funding and referral sources.[500]

RECOVERY MINISTRIES/RECOVERY CHURCHES

Special ministries to alcoholics and addicts began in the closing decades of the nineteenth century, through religion-sponsored urban rescue missions and the creation of rural inebriate colonies. This movement was spawned by pioneering institutions that included the Water Street Mission in New York City and the Salvation Army. A resurgence of such ministries followed the rise of juvenile narcotic addiction in the 1950s and 1960s and included street outreach performed by Father Dan Egan, the "Junkie Priest," in New York City; outpatient

---

[497] Godley, S.H., Passetti, L.L. and White, M.K. (2006). Employment and adolescent alcohol and drug treatment: An exploratory study. *American Journal on Addictions*, 15, 137-143.

[498] Fletcher, C. E. (2004). Experience with peer assistance for impaired nurses in Michigan. *Journal of Nursing Scholarship*, *36*(1), 92-93.

[499] White, W.L., DuPont, R.L., & Skipper, G.E. (2007). Physicians health programs: What counselors can learn from these remarkable programs. *Counselor*, 8(2), 42-47.

[500] 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.

counseling clinics like Saint Mark's Clinic in Chicago; and residential rehabilitation programs like Teen Challenge.

The involvement of the faith community in the problem of addiction and recovery is not new, but this involvement has expanded greatly and taken some stunning new turns. These recent developments exist on a continuum of involvement that spans:

- "recovery-friendly churches" that welcome recovering people but offer no special recovery services;
- churches sponsoring explicitly religious recovery mutual-aid groups such as Celebrate Recovery and 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) whose identities are based on the recovery focus of their ministries;
- new faith-based recovery colonies (residential communities) such as Dunklin Memorial Camp in Okeechobee, Florida;
- a new association of recovery ministries, the National Association for Christian Recovery (http://www.nacronline.com); and
- The growth of non-Christian recovery ministries and support groups such as Millati Islami.

The religious branches of the American recovery movement are experiencing a reawakening and a historically unprecedented degree of influence within the mainstream church. This trend is particularly evident in African American communities[501] and has been aided, in part, by the new Access to Recovery federal initiative described in Chapter Seven.

Most of the research on the role of faith-based recovery ministries is observational rather than controlled. White, Woll, and Webber reviewed the long history of Project SAFE in Illinois, a project aimed at treating addicted women with histories of abuse or neglect of their children. In this review, Project SAFE clinical staff frequently observed that African American women initiated their recovery through traditional frameworks that included professional treatment, AA, NA, and recovery homes, but that later (12-18 months into recovery), many of them shifted to the church as their primary recovery support institution,

[501] Sanders, M. (2002). The response of African American communities to alcohol and other drug problems. *Alcoholism Treatment Quarterly*, *20*(3/4), 167-174. Watson, D.W., Bisesi, L., Tanamly, S., Sim T., Branch, C.A. & Williams, E. (2003). The role of small and medium-sized African-American churches in promoting healthy life styles. *Journal of Religion and Health, 42*(3), 191-200. Williams, C., with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. NY: Harper San Francisco.

particularly to churches that had strong recovery ministries.[502] This finding is consistent with a study by Stewart,[503] who found a link between post-treatment abstinence and regular practice of one's religious faith among African Americans, and Crepe and colleagues'[504] study of 500 former and current injection drug users in Baltimore, in which participation in church functions was strongly associated with sustained abstinence. However, these constitute only preliminary findings and may be contradicted by others. For example, a recent study by Roland and Kaskutas examined the effects of spirituality and religiosity and involvement in AA among African Americans, Caucasians, and Hispanics. One of their findings was that African Americans reported high AA attendance and church attendance at follow-up, but that they were not more likely than other groups to reduce AA participation in tandem with increased church involvement.[505]

Other Recovery Support Structures

Other recovery support structures are also emerging within local communities—recovery advocacy organizations, recovery bookstores, recovery cafes, recovery art co-ops, recovery social networking web sites, recovery athletic teams, and recovery-based travel groups, to name a few—but there are no studies on the influence of participation in these structures on recovery outcomes. Most surprising is that searches of the addictions literature fail to identify focused studies on those recovery support structures most closely linked to addiction treatment: consumer councils and alumni associations.

---

[502] White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago: Illinois Department of Human Services, Office of Alcoholism and Substance Abuse.

[503] Stewart, C. (2007). Religiosity as a predictor of successful post-treatment abstinence for African-American clients. *Journal of Social Work Practice in the Addictions, 7*(4), 75-92.

[504] Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-Step treatment of injection drug users. *Drug and Alcohol Dependence*, *65*, 291-301.

[505] Roland, E.J. & Kaskutas, L.A. (2002). Alcoholics Anonymous and church involvement as predictors of sobriety among three ethnic treatment populations. *Alcoholism Treatment Quarterly*, *20*, 61-77.

Program Profile 18: NET Consumer Council (NorthEast Treatment Centers, Philadelphia, PA)
Purpose: Enhance clients' participation in agency policy development and ownership of their recovery processes.
Service Elements: 1) Weekly Consumer Council meetings with elected consumers and agency representatives; 2) monthly Consumer Recognition Day; 3) *Recovery Focus*, a regular consumer council newsletter; 4) consumer peer mentor program (peer mentors 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 levels of 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: Contact Joseph Schultz (jschultz@net-centers.org)

Today there are growing numbers of new, innovative recovery support institutions developing outside of professional addiction treatment and outside of recovery mutual-aid fellowships. These institutions are likely to exert a profound influence on future opportunities for sustained recovery for individuals, societal attitudes about hope for recovery among people still struggling with addiction, and policymaker attitudes toward investing in recovery, as well as on the future of peer-based support services. In the next chapter, we will review what the science tells us about recovering people who work in the field of addiction treatment as staff and volunteers.

Chapter Six

Scientific Evaluation of Peer-based Services: Studies of Recovering People Working in Addiction Treatment

Summary of Key Findings

- 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 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 *not* found that addiction counselors in recovery are more or less effective than addiction counselors who are not in recovery, but recovering counselors are *as* effective as counselors who are not in recovery
- 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 staff 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.

Science versus Stereotypes

The portrayal of the attitudes, beliefs, knowledge, and performance of recovering people working as addiction counselors, and of their degree of representation in the addiction treatment workforce, continues to be plagued by misconceptions and stereotypes that are contradicted by most scientific studies. The prevailing view is that the majority of addiction counselors are in recovery; that most recovering counselors do not have college or advanced degrees; and that recovering counselors differ in their attitudes, beliefs, knowledge, skills, and effectiveness from addiction counselors without addiction/recovery backgrounds.[506]

Anderson and Wiemer's portrayal in the 1990s of the generally perceived differences between recovering counselors and counselors without a history of addiction varies little from such portrayals in the 1970s.

> 1992: *Professionals are described as formal, impersonal, and calculating, whereas nonprofessionals are described as empathetic, spontaneous, dedicated, optimistic, and immune to manipulation by clients*.[507]

> 1979: *Subjective evaluations have tended to characterize professional and paraprofessional counselors and their orientations toward clients in dichotomous terms. Professional counselors were reputed to be formal, impersonal, and calculating, while paraprofessionals, and especially ex-addict paraprofessionals, were said to be empathic, understanding and spontaneous*.[508]

---

[506] Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596-603.

[507] Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596-603, quotation from p. 596.

[508] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports*. (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

This chapter will separate fact from myth regarding such differences. We will try to draw broad conclusions about the character and level of effectiveness of addiction counselors who are in recovery, while noting that the designation "counselor in recovery" represents not a homogenous group, but men and women with diverse addiction/recovery careers and styles of helping.

Recovery Representation in Addiction Treatment

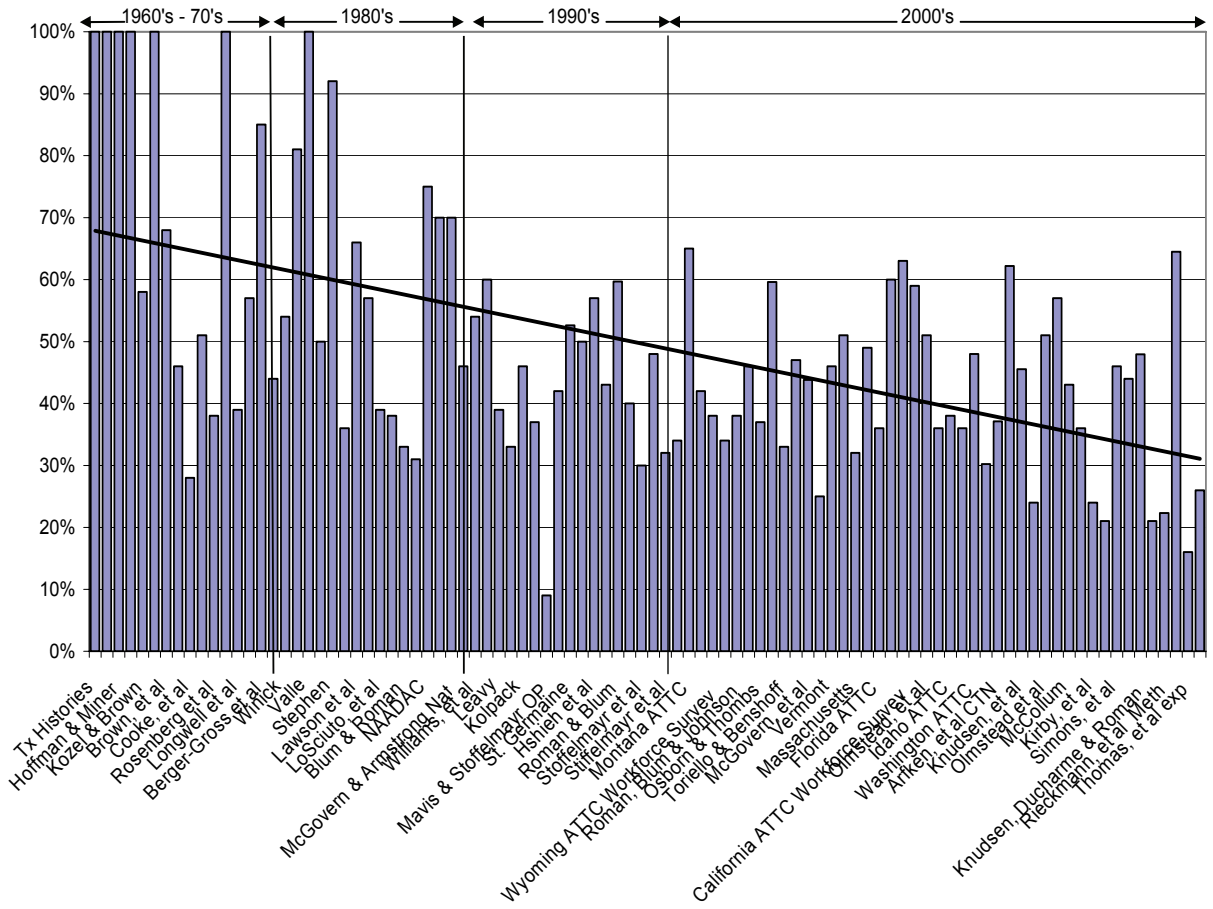
Tenured observers of the addiction treatment field in the United Sates suggest that the percentage of recovering people working as addiction counselors has declined significantly in recent decades,[509] but the change of recovery representation in the addiction treatment field has not been systematically studied. Analyzing this trend is compromised by the fact that many recent clinical studies and surveys of the addiction treatment workforce did not ask participants to indicate their recovery status.[510]

[509] Winick, C. (1990). The counselor in drug user treatment, *International Journal of the Addictions*, *25*(12a), 1479-502. Brown, B. S. (1993). Observations on the recent history of drug user counseling. *The International Journal of the Addictions*, *28*(12), 1243-1255. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[510] The following workforce surveys contain no reference to recovery representation: Forman, R.F., Bovasso, G., & Woody, G. (2001). Staff beliefs about addiction treatment. *Journal of Substance Abuse Treatment*, *21*, 1-9. Knudsen, J.R., Gallon, S.L., & Gabriel, R.M. (2006). Relating substance abuse counselor background to the provision of clinical tasks. *Journal of Psychoactive Drugs*, *38*(4), 473-481. McCarty, D., Forman, R., Fuller, B.E., Laws, R., Arfken, C., Magruder, K.M., et al. (2007). Direct care workers in national drug abuse treatment clinical trials network: Characteristics, opinions, and beliefs. *Psychiatric Services, 58*(2), 181-190. Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, *24*(1), 51-7. Ogborne, A.C., Wildt, T.C., Braun, K., & Newton-Taylor, B. (1998). Measuring treatment process beliefs among staff of specialized addiction treatment services. *Journal of Substance Abuse Treatment*, *15*, 301-312.

Table 10 summarizes recovery representation in the addiction treatment workforce as reported in 39 studies/surveys conducted between 1960 and 2007. (See the Appendix for a detailed presentation of these studies.) The reader's ability to draw conclusions from this data is challenged by the different ways in which such information has been collected. Some workforce surveys and studies ask participants to note their recovery status, some ask for designation of family recovery (existence of a participant's family member in recovery), some combine these categories, and more recent workforce surveys are less likely to ask questions related to recovery status.

Table 10: Recovery Representation Among Counselors Working in Addiction Treatment: 1960-2007[1]



If all recovery representation reports are reviewed by decade, several conclusions can be drawn.

- Histories and studies of addiction treatment from the mid-1960s through the early 1970s note very high recovery representation rates, with counseling staff from many residential alcoholism treatment programs and residential therapeutic communities reporting rates of recovery representation between 60% and 100%. Recovery representation in early outpatient treatment and methadone maintenance treatment programs was considerably lower.
- Between 1974 and 1975, staff recovery representation rates dropped to approximately 50%.
- In the early 1980s, staff recovery representation dropped into the 30th percentile, but these data were reported in local studies and may not be representative of national trends. Winick (1991)[511] found that staff recovery representation rates in New York City's therapeutic communities had dropped from nearly 100% to 54%. One national study of this period[512] reported a 57% recovery representation rate among alcoholism counselors.
- National studies between 1984 and 1990[513] report staff recovery representation rates ranging from 39% to 75%.
- During the 1990s, recovery representation rates in available state surveys ranged from 39% to 46%, and two national surveys revealed staff recovery representation rates of 57%[514] and 59.7%,[515] the latter reflecting a survey of 400 private addiction treatment programs. By 2002, staff recovery representation in this same sample of private programs declined to 39%.[516]
- Between 2000 and 2008, staff recovery representation rates in available surveys ranged from 25% to 65%, with most studies reporting rates in the 30th and 40th percentiles.
- Recovery representation in public-sector treatment is highest in those modalities treating clients with the highest degrees of problem severity

---

[511] Winick, C. (1991). The counselor in drug user treatment. *International Journal of the Addictions*, *25*(12A), 1479-1502.

[512] Birch & Davis Associates (1983). *Development of model professional standards for counselor credentialing*. Rockville, MD: NIAAA.

[513] LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, *19*(3), 233-252. McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, *4*(1), 43-60. NAADAC (1986). *Survey of substance abuse counselors*. Arlington, VA: NAADAC: The Association of Addiction Professionals.

[514] Hsieh, S.Y. & Srebalus, D.J. (1997). Alcohol treatment issues: Professional differences. *Alcoholism Treatment Quarterly*, *15*(4), 63-73.

[515] Roman, P. & Blum, T. (1999). *National Treatment Center Study: Summary Report (No. 4): Results of Treatment Center Staff Questionnaires and New Center / Old Center Comparisons*. Athens, GA: Institute for Behavioral Health.

[516] Roman, P., Blum, T., & Johnson, A. (2002). *National Treatment Center Study: Summary Report (No. 5): Third Wave Results.* Athens, GA: Institute for Behavioral Health.

and complexity (detoxification and residential treatment); for-profit, hospital-based addiction treatment programs have the lowest representation of recovering people working as counselors.[517]

- Recovery representation is higher in abstinence-based programs than in medication-assisted recovery programs.[518]
- Recovery representation among counselors working in Minnesota Model alcoholism programs and drug-free therapeutic communities has declined from nearly 100% in the 1960s to below 60%.

What have not been reported consistently enough to note trends are recovery representation status trends by age, gender, ethnicity, and drug choice, and only sparse information exists on recovery representation among persons filling non-clinical recovery support service roles.

Program Profile 19: Peer Specialist Initiative (Philadelphia, PA)[519]
Purpose: 1) Demonstrate to service recipients, service professionals and behavioral health leaders the value that experiential wisdom and experience-based skills can add to the service system; 2) increase the number of Certified Peer Specialists throughout the Philadelphia behavioral health care system; 3) create employment opportunities for people in recovery; 4) develop agency norms that celebrate hope for recovery and nurture the development of peer recovery cultures; 5) cultivate more active, more participatory roles for service consumers. (Initiative launched November, 2006)
Service Elements: 1) Recruitment, 2) interview/orientation on nature of training/certification, 3) two-week peer specialist training program (20 per class), 4) consultation with peers to evaluate effects of employment on Social Security Disability benefits, 5) program orientation for agency leaders, 6) two-day training program for supervisors of peer specialists, 7) monthly peer specialist development seminars for graduates, 8) bi-monthly seminars for agency supervisors of peer specialists.
Volume/Status: A total of 130 peer specialists trained and certified to-date.

[517] Mulligan, D.H., McCarty, D., Potter, D., & Krakow, M. (1989). Counselors in public and private alcoholism and drug abuse treatment programs. *Alcoholism Treatment Quarterly*, *6*(3-4), 75-89. Rieckmann, T., Daley, M., Fuller, B.E., Thomas, C.P., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications for treatment of opioid dependence. *Journal of Substance Abuse Treatment*, *32*, 207-215. Roman, P. & Blum, T. (1998). *National Treatment Center Study: Summary Report (No. 3): Second Wave On-Site Results.* Athens, GA: Institute for Behavioral Health.

[518] Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1987). Attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, *175*, 653-660. Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1988). Differences among treatment clinic types in attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, *176*, 714-718.

[519] Personal communication with Joan King and Tom O'Hara, November/December 2008.

Peer Specialist Initiative (Continued)
Service Outcomes: 90% of those enrolled achieved successful certification; all those certified received six college credits; 76 graduates hired—74% full time and 26% part time; 72.5% of those hired are still employed (a high retention rate in a field noted for high staff turnover); a survey is underway to evaluate obstacles faced by those certified but not yet hired. Agencies with peer specialists now viewed as being on "cutting edge"; there is competition to develop peer specialists within agencies.
Service Lessons: 1) Infrastructure of program (above-listed elements) is crucial to success, 2) financial incentives and system-wide recognition of peer initiatives aid recruitment of participating agencies, 3) agency competition is part of initiative-aided success, 4) peer specialist initiative generated a contagious energy that helped agencies transform themselves, 4) requiring each organization to submit a transformation plan for the program in which the peer specialist would be employed prevented the peer specialist initiative from becoming an appendage to an otherwise unchanged program.
For More Information: Contact Tom O'Hara at Tom.OHara@phila.gov or 215-410-0445

THE ROLE TRANSFORMATION OF ADDICTION COUNSELORS IN RECOVERY

There are no formal studies on how the core activities and service relationships of the non-degreed, "paraprofessional" recovering counselor has changed through professionalization of the addiction counselor role. It may be that no significant differences ever existed between recovering counselors and counselors without addiction histories, or that differences once existed but those differences were erased through the processes of academic/professional education and socialization.

Our earlier historical review suggests that the core ideas, functions, and relational style of the addiction counselor have changed throughout the era of professionalization. These have included changes in attitudes toward self-disclosure, role model functions, liaison with recovery communities, experience-based recovery coaching, seeing clients in their natural environments, and socializing with clients.[520] Such changes are important in that they set the stage for their revival through P-BRSS. As traditional professionals assumed ownership of the addiction treatment field, the frequent unspoken message to recovering counselors entering the field was, "You can join us if you forsake your recovery identity and learn to think, feel, speak, look, and act like us." If the professionalization of recovering counselors has eliminated the unique ingredients that historically contributed to the recovery support process, and if they are now indistinguishable from professional helpers without recovery background, then recovery representation in the field no longer has meaning or value.

[520] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

The recovery status of the helper has meaning only if that status contributes something to the recovery experience that is not provided by people not in recovery. As more scientific investigation of P-BRSS takes place, it is critical that information on recovery status and other ingredients be examined carefully. For example, the issue of recovery representation will be moot if the recovery status of people working in treatment as P-BRSS service providers cannot be disclosed, or if these employees cannot draw upon their experiential knowledge and relational connections with local recovery communities in the performance of their roles—and clients cannot draw upon their own knowledge of that recovery status as a source of hope and a model for recovery-based decision-making and living.

In their description of the value of paraprofessionals in the treatment and recovery process, Talbott and colleagues[521] observed: "We see the paraprofessional's talents and skills as different from the professional's, rather than merely an extension of them." Early alcoholism counselors feared that these talents might be lost in the rush to professionalize the field.

> *With standardization comes an exclusiveness, an isolation, a power block, a kind of thinking and procedure that mitigates against an informality that has characterized the counselor's worth. Efforts at certification and qualification standards for AA member-alcoholism counselors should be approached slowly and prudently*.[522]

In the subsequent professionalization of addiction counseling, we may well have diluted if not lost those unique qualities.

> *We first rendered the peer helpers extensions of the professional (by defining them as "paraprofessional"), then we turned the peer helper into a professional (through the escalating requirements of education, certification, and licensure). In the transition from paraprofessional to professional, recovering counselors took on the trappings of power and authority and forged traditional service relationships in which the "new profession" was protected but the client was abandoned. We conveyed that separation in a thousand subtle ways: our gatekeepers (secretaries), the required rituals of access, our titles, our dress, our desks, our posted degrees and certificates, our office bookshelves, our language, our use of diagnoses and labels, our papers and protocols—even separate bathrooms. We entered the field speaking the "language of the heart" and shed that language in exchange for a professional argot that elevated our status but distanced us from those we were pledged to serve* (Author, excerpt from personal journal).

---

[521] Talbott, J. A., Ross, A. M., Skerrett, A. F., Curry, M. D., Marcus, S. I., Theodorou, H., & Smith, B. J. (1973). The paraprofessional teaches the professional. *American Journal of Psychiatry*, *130*, 805-808.

[522] McInerney, J. (1973). Alcoholics Anonymous members as alcoholism counselors. In G. Staub & L. Kent (Eds.), *The para-professional in the treatment of alcoholism* (pp. 91-105). Springfield: IL: Charles C. Thomas Publisher.

This raises the question of whether we "train out the best qualities and characteristics"[523] of those entering the field. There is a clear trend toward decreased face-to-face time between counselor and client, greater task orientation in the counseling process, and a decreased focus on issues that have a direct nexus to long-term recovery outcomes.[524] In this context, distinctions that once existed between the features of recovering counselors and those of counselors without addiction histories may well have dissipated. The same may well be said for recovering people working as physicians, nurses, psychologists, and social workers in addiction treatment.

Why are the service needs and recovery supports being addressed within the framework of P-BRSS not addressed by the addiction counselor? The progressive erosion of recovery representation within the addiction counseling field and the new professional etiquette of addiction counseling diminished the early peer qualities of the service relationship. As the addiction counselor's role came to resemble the roles that had preceded it (psychologist, social worker, mental health counselor), conditions were set for the emergence of a new role that recaptured these peer qualities. P-BRSS constitute, not a new chapter in the history of addiction recovery, but an effort to retrieve something of past value that was lost.[525]

This discussion is intended to demean neither the process of professionalization nor those, including the author, who invested most of their careers in this goal. But it is intended to raise the question of whether our focus on the professional and administrative structures and processes established to ensure the quality of addiction treatment have diverted our eyes from the ultimate outcome of care (recovery). The message here for addictions professionals is that one must resist and regularly mend the disconnection between what we are doing and why we are doing it. There are service professionals who will be allies in this effort to renew addiction treatment and to create more authentic and more person/family-centered service relationships. The ultimate goal of professional care is long-term recovery. Professional structures of helping must be constantly refocused on that goal. Adding P-BRSS as a band-aid on addiction treatment as a system of care will not, by itself, mend this breach.[526]

> *The validity of the work of recovering persons and of peer-based support lends credence to the community of professionals who want more than the rigid boundaries that regulation and habit of mind have imposed. There are many professionals who are encouraged by what peer support*

---

[523] Wolf, S. (1974/1975). Counseling—for better or for worse. *Alcohol Health and Research World*, *Winter*, 27-29.

[524] Toriello, P.J. & Strohmer, D.C. (2005). Addictions counselors' credibility: The impact of interactional styles, recovery status, and nonverbal behavior. *Journal of Addictions and Offender Counseling*, *25*(1), 43-57. 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.

[525] White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor*, 5(6), 20-22.

[526] Special thanks to David Dan for our discussion of these points.

services are adding to the recovery process and who are using the lessons from peer support to renew their own professional service work.[527]

DEMOGRAPHIC PROFILE OF COUNSELORS IN RECOVERY

There are no national workforce studies that reveal the demographics of recovering and nonrecovering counselors working in addiction treatment; however, some early work suggests potentially important differences. LoScioto and colleagues[528] reviewed staffing patterns at five drug addiction treatment programs in the 1970s and found that ex-addict counselors were more likely than professional counselors to be male (60% vs. 48%) and older (39 vs. 29), and less likely to be Caucasian (22.6% vs. 67.7%). While profound changes have occurred in the composition of the addiction treatment workforce,[529] recent studies offer no profile of recovering people working in the field and no clear sense of how that profile has changed over the past 40 years.

The profile of recovering people entering the addiction treatment field does have relevance to larger workforce development issues. Women now make up from 50 to 70% of the addiction treatment workforce, although 68% of clients admitted to addiction treatment are men.[530] Similarly, less than 10% of the addiction treatment workforce is non-white, while 43% of clients admitted to addiction treatment are people of color.[531] As the field of addiction treatment has become a less desirable and less financially viable occupational choice for men, recruitment of men in recovery may be an essential strategy for developing some degree of match between the gender of clients and service providers. Recruitment of recovering people of color may achieve a similar goal in terms of ethnic and cultural representation.

PRIOR TREATMENT/RECOVERY EXPERIENCE OF COUNSELORS IN RECOVERY

There has been no systematic review of the personal treatment and recovery histories of people working as addiction counselors. Little is known of their prior treatment experience (the type, number, and duration of past treatment episodes), the length of stable recovery prior to beginning work as an addictions

---

[527] Personal communication with David Dan, December 2008.

[528] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

[529] Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment. Retrieved from http://www.oas.samhsa.gov/TEDS2k6highlights/Tbl2b.htm.

[530] Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan.* Rockville, MD: Center for Substance Abuse Treatment.

[531] Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, *24*(1), 51-7.

counselor, recovery pathways (religious, spiritual, secular), or past/present involvement in recovery mutual-aid groups. Only one study from the 1970s was found that touched on these issues—a study noting that recovering counselors in the drug abuse programs studied had spent a median length of 22 months in treatment within a variety of programs (drug free, chemically supported detoxification, and methadone maintenance).[532]

PRE-SERVICE EDUCATIONAL FUNCTIONING OF COUNSELORS IN RECOVERY

Koch and Blanco[533] conducted a study that compared the academic performance of two groups of students in an "Alcohol, Drugs and Society" course. The groups compared were 1) general study students and 2) students, an unreported number of whom were in recovery, who were preparing to become addiction counselors. There were no differences in academic performance between these counselors-in-training and others taking the course. Koch and Blanco concluded, "There is no evidence that pre-professionals get caught up in a paradigm shift which creates academic problems for them…" (p. 89).[534] This confirms findings of an earlier evaluation of an alcoholism counselor training program that found no differences in cognitive learning gains between non-alcoholics and recovering alcoholics preparing to be alcoholism counselors.[535] Similarly, performance on certification tests has been linked to educational levels but not to recovery status.[536]

EDUCATIONAL LEVELS OF RECOVERING PEOPLE WORKING AS ADDICTION COUNSELORS

Recovering counselors as a group have fewer years of educational training compared to counselors without addiction/recovery backgrounds, but the degree of difference in levels of education has narrowed since the 1970s.[537] Two

---

[532] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

[533] Koch, J.R. & Blanco, J.D. (2001). Studying "alcohol, drugs, and society" from a sociological perspective: Comparing the academic performance of pre-professionals in addiction studies with students majoring in other disciplines. *Alcoholism Treatment Quarterly*, *19*(4), 81-90.

[534] Koch, J.R. & Blanco, J.D. (2001). Studying "alcohol, drugs, and society" from a sociological perspective: Comparing the academic performance of pre-professionals in addiction studies with students majoring in other disciplines. *Alcoholism Treatment Quarterly*, *19*(4), 81-90.

[535] Gideon, W.L., Little, A.S., & Martin, D.W. (1980). Evaluation of a training program for certified alcoholism counselors. *Journal of Studies on Alcohol*, *41*, 8-20.

[536] Arneson, A.H., Ruben, D.H., & Husain, S. (1984). Credentialing of substance abuse counselors: A field evaluation. *Journal of Drug Education*, *14*(4), 297-306.

[537] Bokos, P. J. (1974). Education and training for drug abuse paraprofessional staff. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1037-1040). Cambridge, MA: Schenkman. McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, *4*(1),

surveys conducted in the 2003-2004 period are revealing. The first found that more than 70% of addiction counselors have some college education, with 29% reporting a bachelor's degree, 27% a master's degree, and 5% a doctorate.[538] The second survey found that 79.9% of addiction treatment professionals have at least a bachelor's degree and 48.6% have a master's degree.[539] The percentage of recovering counselors today who have college or advanced degrees has not been reported. The increased educational requirements for addiction counselor certification and licensure has contributed to the shrinking recovery representation in the field and the likely increase in the educational credentials of people in recovery who today work as addiction counselors.

While educational levels are increasing among addiction counselors, only 55% of states require a bachelor's degree to work as an addictions counselor. By contrast, 98% of states require a master's degree to work as a mental health counselor.[540] The superiority of the allied health professional model (with its reliance on educational preparation) over the apprenticeship model (which has an emphasis on experiential preparation and mentorship by a professional elder) has yet to be established in the addiction treatment and recovery support arenas. (See later discussion on recovery outcomes.)

CERTIFICATION, LICENSURE, AND CLINICAL EFFECTIVENESS

Many factors led to the drive for certification and professional licensure of "alcoholism counselors" and "drug abuse counselors" during the pre-professional years of addiction treatment. Many of these focused on potential gains for:

- the maturing field (buttressing the field's claim to cultural ownership of AOD problems),
- local treatment organizations (achieving organizational status among allied service organizations and referral sources, compliance with new accreditation standards, service reimbursement from third-party payors, and reduced organizational liability),
- addiction counseling as a profession (achieving professional status and protecting newly acquired professional turf), and

---

43-60. Stöffelmayr, B.E., Mavis, B.E., & Kasim, R.M. (1998). Substance abuse treatment staff: Recovery status and approaches to treatment. *Journal of Drug Education*, *28*(2), 135-145.

[538] Libretto S.V., Weil, J., Nemes, S., Linder, N.C., & Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs*, *36*(4), 489-97.

[539] Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, *24*(1),51-7.

[540] Kerwin, M.E., Walker-Smith. K., & Kirby, K.C. (2006). Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment*, *30*(3), 173-81.

- the addiction counselor (acquiring occupational status, a legitimized role within multidisciplinary teams, professional confidence, and enhanced income potential and career opportunities).[541]

These larger interests were nested within the proposition that credentialing addiction counselors would protect and benefit consumers of addiction treatment.

College-based and independent preparatory addiction studies programs, clinical training programs, and addiction counselor certification programs became major sub-industries within the larger industrial economy of addiction treatment. The goal was to professionalize the paraprofessional recovering counselor or replace that counselor with professionals credentialed by education. In spite of the efforts toward this goal over nearly four decades, the proportion of addiction counselors who are certified or licensed varies across states from 45% to 72%.[542] In 2004, there were more than 130,000 direct service staff working within addiction treatment programs in the United States, and of those who filled counseling roles, only half were certified by one of the 66 organizations that credential counselors.[543]

Surprisingly, there is a marked lack of scientific evidence that counselor education, certification, or licensure have elevated the long-term recovery outcomes of consumers of specialty-sector addiction treatment. Studies to-date have not found differences in effectiveness between degreed and non-degreed addiction counselors,[544] and no studies were found in this review that specifically evaluated whether clients of certified or licensed counselors achieve better recovery outcomes than clients of counselors who are not certified or licensed. What little evidence we do have confirms considerable differences across counselors in clients' short-term (treatment engagement and retention) and long-term (post-treatment recovery status and level of global health and functioning) outcomes, but these are unrelated to such factors as age, gender, race, education, or certification status.[545] Only a minority of studies have found these

---

[541] Amodeo, M. (2006). Securing an equal role for substance abuse counselors: A commentary on Kerwin, Walker-Smith, and Kirby. *Journal of Substance Abuse Treatment*, *30*, 169-170.

[542] Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment.

[543] Libretto S.V., Weil, J., Nemes, S., Linder, N.C., & Johansson, A. (2004). Snapshot of the substance abuse treatment workforce in 2002: A synthesis of current literature. *Journal of Psychoactive Drugs*, *36*(4), 489-97.

[544] Valle, S.K. (1977). Relative effectiveness of degreed and non-degreed alcoholism counselors. *Maryland State Medical Journal*, *26*(11), 12-14. Gideon, W.L., Little, A.S., & Martin, D.W. (1980). Evaluation of a training program for certified alcoholism counselors. *Journal of Studies on Alcohol*, *41*, 8-20.

[545] Connors, G.H., DiClemente, C.C., Dermon, K.H., Kadden, R., Carroll, K.M., & Frone, M.R. (2000). Predicting the therapeutic alliance in alcoholism treatment. *Journal of Studies on Alcohol*, *61*, 139-149; Mendelsohn, G.A. & Geller, M.H. (1965). Structure of client attitudes toward counseling and their relation to client-counselor similarity. *Journal of Consulting Psychology*, 29, 63-72. Sterling, R.C., Gottheil, E., Weinstein, S.P & Serota, R. (2002). Therapist/patient race and sex matching: Treatment retention and 9-month follow-up outcome. *Addiction*, 93, 1043-1050. Gottheil, E., Sterling, R.C., Weinstein, S.P., & Kurtz, J.W. (1994). Therapist/patient matching and early treatment drop-out. *Journal of Addictive Diseases*, 13(4), 169-76.

factors of significance to intermediate outcomes,[546] and no well designed studies were located that draw a clear connection between enhanced recovery rates and counselor education or certification. (See later discussion on recovery status of counselors and client recovery outcomes.)

Compensation of Recovering Counselors versus Counselors without a History of Addiction

Administrators of addiction treatment programs report no perceived differences between the effectiveness of recovering counselors and that of counselors without a history of addiction,[547] but they pay the former less for comparable work. Olmstead and colleagues[548] analyzed salary data within the 2002-2003 National Treatment Center Study and found that, when other factors such as education, years of experience, and certification/licensure are controlled, recovering counselors receive $1,000-$2,580 per year lower salary compensation than do counselors who do not have a history of addiction. They theorize that this lower compensation is related to two factors: 1) fewer job alternatives for recovering counselors and 2) the willingness of recovering counselors to work for less pay in jobs to which they feel "called." This author would suggest a third possibility: that lower compensation for equivalently educated recovering counselors reflects the unrecognized internalization of social stigma within the addiction treatment field.

Personality Characteristics of Recovering Addiction Counselors

Studies of the personalities of recovering men and women working as addiction counselors reveal few differences from counselors without addiction/recovery backgrounds.[549] Shipko and Stout (1992) conducted a study

---

[546] Meir, P.S., Donmall, M.C., Barrowclough, C., McElduffm P., & Heller, R.F. (2005). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction, 100*, 500-511. Siqueland, L., Crits-Christoph, P., Barber, J.P., Butler, S.F., Thase, M., Najavits, L., et al. (2000). The role of therapist characteristics in training cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. *Journal of Psychotherapy Practice Research*, *9*(3), 123-130.

[547] Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596-603.

[548] Olmstead, T.A., Johonson, J.A., Roman, P.M., & Sinclair, J.L. (2005). What are the correlates of substance abuse counselor salaries? *Journal of Substance Abuse Treatment, 29*, 181-189. Olmstead, T. (2007). Why are recovering counselors paid less? *Substance Abuse*, *28*(1), 31-44.

[549] Hoffman, H. & Miner, B.B. (1973). Personality of alcoholics who became counselors. *Psychological Reports*, *33*, 878. Hoffmann, H. & Bonynge, E.R. (1977). Personalities of female alcoholics who became counselors. *Psychological Reports, 41*(1), 37-38.

of personality characteristics of addiction counselors that included such issues as capacity for empathy, flexibility, and tolerance. They concluded that "…there were no significant differences between the recovering alcohol counselors and non-alcoholic counselors…"[550] The general conclusion of these studies is that counselor effectiveness is related to particular traits that are not linked to recovery or non-recovery status.[551] The only exception to these general findings is a 1975 study by Jansen and Hoffman.[552] Their study concluded that some enduring traits of "addictive personalities" remained after recovering alcoholics had been trained as alcoholism counselors, but drew no conclusions as to whether such traits hindered or aided effective addiction counseling.

Beliefs and Attitudes of Recovering Addiction Counselors

Numerous studies have been conducted—most in the 1970s—to evaluate differences in the beliefs and attitudes of addiction counselors based on the presence or absence of personal addiction recovery. LoSciuto and colleagues[553] found no substantial differences based on recovery status in counselors' views on such issues as the etiology of addiction or factors related to treatment success.

> *The attitudinal similarity of the three counselor groups* [professional counselors, ex-addict counselors, and non-ex-addict paraprofessionals], *regardless of education, work, and life experience, and regardless of attitudinal area investigated, is most striking.*[554]

In 1987, McGovern and Armstrong[555] conducted a state (Texas) and national (NAADAC membership) survey of addiction counselors that compared the characteristics of recovering and non-alcoholic counselors. Although recovering counselors were more likely to be male, certified, and less well educated than non-alcoholic counselors, the two groups expressed similar attitudes toward treatment-related issues. Like the McGovern and Anderson study, most early studies reveal few if any differences by counselor recovery

---

[550] Shipko, J. & Stout, C. (1992). A comparison of the personality characteristics between the recovering alcoholic and non-alcoholic counselor. *Alcoholism Treatment Quarterly, 9*, 207-214, quote from page 211.

[551] Covner, B. (1969). Screening volunteer alcoholism counselors. *Quarterly Journal of Studies on Alcohol, 30*, 420-425.

[552] Jansen, D.G. & Hoffman, H. (1975). MMPI scores of counselors on alcoholism prior to and after training. *Journal of Consulting and Clinical Psychology*, *43*, 271.

[553] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

[554] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

[555] McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, *4*(1), 43-60.

status on perceptions of drinking behaviors or beliefs about addiction and addiction treatment.[556] LoSciuto, Aiken, Ausetts, and Brown (1984) note this central finding:

> *The similarities in responses…of counselors are much more impressive than are the differences…The groups conceive of the etiology of drug abuse, the nature of drug abusers, the factors critical for drug treatment and the lasting outcomes of treatment as essentially the same….*[557]

But they did find some qualitative differences worth noting:

> *While clients of the three groups viewed their counselors as equally able to understand them and were equally confident in their counselors, the clients of ex-addict counselors saw their counselors as more knowledgeable about critical issues of drugs and the street scene, were more willing to bring personal problems to their counselors, and expected and desired more participation from their counselor in both counseling-related and personal problems.*[558]

LoSciuto, Aiken, Ausetts, and Brown (1984)[559] also found that ex-addict counselors were more positive about their clients' prospects for recovery.

Other studies of counselor beliefs and attitudes have contradictory findings. Some conclude that recovered counselors more strongly embrace the conception of addiction as a disease[560] and abstinence as a treatment goal (and are less supportive of a moderation goal) than counselors without a history of

---

[556] Humphreys, K., Noke, J.M., & Moos, R.H. (1996). Recovering substance abuse staff members' beliefs about addiction. *Journal of Substance Abuse Treatment*, *13*, 75-78. Leavy, R.L. (1991). Alcoholism counselors' perceptions of problem drinking. *Alcoholism Treatment Quarterly*, *8*(3), 47-55. Roach, E.F. (2005). Counselor prejudice, history of recovery, and client race/gender as predictors of counselor assessments of substance-abusing clients, Dissertation, Fordham University. *Dissertation Abstracts International, 66*(03B), 1733. Skuja. A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Drug and Alcohol Dependence*, *8*(1), 61-68.

[557] LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, *19*(3), 233-252, quotation from p. 249.

[558] LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, *19*(3), 233-252, quotation from p. 234.

[559] LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, *19*(3), 233-252.

[560] Bennett, N. & Kelly, L.S. (1987). Assessing the acceptance of the disease concept of alcoholism among EAP practitioners. *Journal of Drug Issues*, *17*, 281-289. Ferneau, E. & Paine, H. (1972). Attitudes regarding alcoholism: The volunteer alcoholism clinic counselor. *British Journal of Addiction*, *67*, 235-238. Schaler, J.A. (1995). The Addiction Belief Scale. *International Journal of the Addictions*, *30*, 117-134.

addiction.[561] Other studies conclude that beliefs of addiction counselors are shaped primarily by education rather than recovery status[562] and that recovering counselors use a broader range of techniques and embrace a broader range of treatment goals than do counselors not in recovery.[563] Crabb and Linton[564] found that addiction counselors in recovery were no more likely than counselors not in recovery to believe that alcoholics could not learn moderate drinking.[565] Equally striking in this study was the finding that counselors in recovery held the most non-traditional beliefs and were more likely to change their belief systems about addiction, treatment, and recovery over the course of their counseling careers—findings confirmed in other studies.[566] There is a need to confront stereotypes in this arena. Humphreys, Noke, and Moos conducted a study of counselor attitudes and concluded:

> *Because recovering staff have a varied educational background and come from diverse disciplines, treatment professionals who hire, supervise and work with recovering staff should not assume that being in recovery necessarily implies a particular perspective on treatment. The regression equations demonstrate that recovery status is a less consistent predictor of beliefs than are other factors*.[567]

---

[561] Skuja. A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Drug and Alcohol Dependence*, *8*(1), 61-68. Wallace, S.E. (1994). Attitudes and beliefs of certified substance abuse counselors**.** *Dissertation Abstracts International*, *55*(3), 1226-B.

[562] Kolpack, R. (1992). Credentialing alcoholism counselors. *Alcoholism Treatment Quarterly, 9*, 97-112. Leavy, R.L. (1991). Alcoholism counselors' perceptions of problem drinking. *Alcoholism Treatment Quarterly*, *8*(3), 47-55.

[563] Stöffelmayr, B.E., Mavis, B.E., & Kasim, R.M. (1998). Substance abuse treatment staff: Recovery status and approaches to treatment. *Journal of Drug Education*, *28*(2), 135-145. Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, *31*(2), 121-127.

[564] Crab, A.C. & Linton, J.M. (2007). A qualitative study of recovering and nonrecovering substance abuse counselors' belief systems. *Journal of Addictions and Offender Counseling*, *28*(1), 4-20.

[565] This perception does differ between recovery alcoholic counselors and professional social workers employed outside of addiction treatment, with the social workers perceiving greater likelihood of successful moderation of drinking by alcoholics. Chambers, P.R. (1982). An examination of paraprofessional recovering alcoholic counselor variables and their effect on therapeutic outcome. Dissertation, United States International University. *Dissertation Abstracts International*, *43*(02B), 0518.

[566] Sorensen, K.L. (1998). Addiction counselor trainees' receptivity to non-traditional information about alcoholism. *Dissertation Abstracts International*, *59*, Z5055. Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, *31*(2), 121-127.

[567] Humphreys, K., Noke, J.M., & Moos, R.H. (1996). Recovering substance abuse staff members' beliefs about addiction. *Journal of Substance Abuse Treatment*, *13*, 75-78, quotation from page 77.

Humphreys was even more explicit on this point in his 2004 review: "When level of education is taken into account, recovering staff are no more likely to endorse a 12-Step style disease model than non-recovering staff…."[568]

Thombs and Osborn (2001)[569] used cluster analysis to create a typology of three different clinical orientations of addiction counselors: a uniform group that minimized client differences, a multiform group that embraced diverse beliefs about addiction and recovery, and a client-directed group that recognized client heterogeneity and the high need for individual counseling. Their conclusions are consistent with Humphreys:

> *The findings of this study challenge the descriptions, or perhaps the stereotype, of chemical dependency counselors as a monolithic group strident in its advocacy of the disease model and closed to other treatment options. It is noteworthy that counselors in recovery were not concentrated in any particular cluster*.[570]

Existing studies have tended to focus on dichotomous comparisons between recovering counselors and counselors with no history of addiction. Further studies of intragroup differences among recovering counselors and recovering people filling other roles will likely underscore the lack of homogeneity and in fact the rich diversity that exists among addiction counselors in recovery. It appears that the image of the recovering counselor as a person who is resistant to new knowledge and clinical practices is a stereotype lacking factual foundation.[571]

Treatment setting also exerts an influence on the attitudes and beliefs of recovering counselors and counselors without history of addiction. Berger-Gross and Lisman[572] compared the attitudes toward alcoholism of paraprofessionals working in a state hospital with those of paraprofessionals working in a detoxification center (85% of each group was in recovery). Attitudes varied by setting, with those paraprofessionals working in the detoxification center exhibiting far less tolerant attitudes. Brown, Jansen, and Bass[573] conducted a study of attitudes regarding the use of methadone in the treatment of heroin addiction among three groups of staff: ex-addict counselors, ex-addict counselors who were maintained on methadone, and non-addict counselors. All

---

[568] Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press, quote from page 175.

[569] Thombs, D.L. & Osborn, C.J. (2001). A cluster analytic study of clinical orientations among chemical dependency counselors. *Journal of Counseling and Development*, *79*, 450-458.

[570] Thombs, D.L. & Osborn, C.J. (2001). A cluster analytic study of clinical orientations among chemical dependency counselors. *Journal of Counseling and Development*, *79*, 450-458.

[571] Campbell, T. C., Catlin, L. A., & Melchert, T. P. (2003). Alcohol and other drug abuse counselors' attitudes and resources for integrating research and practice. *Journal of Drug Education, 33*(3), 307-323.

[572] Berger-Gross, V. & Lisman, S. (1979). Attitudes of paraprofessionals toward alcoholism: Setting effects. *Journal of Studies on Alcohol, 40*, 514-517.

[573] Brown, B.S., Jansen, D.R., & Bass, U.F. (1974). Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction. *American Journal of Psychiatry*, *131*(2), 215-219.

three groups were ambivalent about methadone and expressed attitudes suggesting that the use of methadone reflects "a certain lack of personal integrity on the part of those clients as compared with clients who have become abstinent."[574]

Brown and colleagues expressed concern that such attitudes could be conveyed to clients in methadone treatment and exert pressure for premature termination of treatment. The legitimacy of their concern was validated by later studies related to the shame and stigma ("dirty little secret") experienced by those taking methadone for treatment of opiate addiction.[575] Subsequent studies also confirmed continuation of an abstinence bias (a view that methadone should be time limited and that recovery begins only when methadone treatment is terminated) among frontline MMT counselors and nurses[576] and the link between abstinence orientation and shorter lengths stay in MMT.[577] This is of particular concern given studies confirming that MMT outcomes improve when a minimal threshold of at least one year has been reached[578] and that dropout rates are linked to clients' misconceptions about methadone and negative attitudes toward MMT.[579] Staff pressure to move toward termination of methadone maintenance is also of concern due to the high post-discharge relapse rates (70%+) and increased death rates linked to the loss of drug tolerance.[580]

---

[574] Brown, B.S., Jansen, D.R., & Bass, U.F. (1974). Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction. *American Journal of Psychiatry*, *131*(2), 215-219, quote from page 218.

[575] Murphy, S. & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1988). Differences among treatment clinic types in attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, *176*, 714-718. White, W. & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor, 4*(5), 58-63.

[576] Caplehorn, J. R., Hartel, D. M., & Irwig, L. (1997). Measuring and comparing the attitudes and beliefs of staff working in New York methadone maintenance clinics. *Substance Use & Misuse, 32*(4), 399-413.

[577] Caplehorn, J. R., Lumley, T. S., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence, 52,* 57-61.

[578] Simpson, D.D. & Joe, G.W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, *27*, 99-121.

[579] Kayman, D.J., Goldstein, M. F., Deren, S., & Rosenblum, A. (2006). Predicting treatment retention with a brief "Opinions about methadone" scale. *Journal of Psychoactive Drugs*, *38*(1), 93-100.

[580] Coviello, D.M., Zanis, D.A., Wesnoski, S.A., & Alterman, A.I. (2006). The effectiveness of outreach case management in re-enrolling discharged methadone patients. *Drug and Alcohol Dependence*, *85*, 56-65. Strang, J., McCambridge, J., Best, D., Beswick, T., Bearn, J., Rees, S., et al. (2003). Loss of tolerance and overdose mortality after inpatient opiate detoxification: Follow up study. *British Medical Journal, 326*, 959-960. Zanis, D.A. & Woody, G.E. (1998). One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence*, *52*(3), 257-260.

Attitudes and Behaviors of Recovering Counselors Related to Evidence-based Practices

In discussing evidence-based practices in addiction treatment, one sometimes hears the comment that counselors in recovery resist new evidence-based practices in favor of traditional models of treatment. To further explore the character and performance of the recovering counselor, we will test this proposition by reviewing studies that illuminate whether such resistance is a reality or a myth. The major findings of counselor attitudes toward evidence-based practices reveal the following:

- University and medical center research sites have a far lower representation of recovering staff than community-based sites, which might influence study findings and transfer of knowledge from research to community service sites.[581]
- The addictions field has promoted advanced educational and certification requirements regardless of recovery status.[582]
- Few differences exist in theoretical orientation or use of treatment techniques as a function of recovery status;[583] "12-Step orientation" is often considered a proxy for recovery status among addiction counselors, but such orientation is related more to the factors of education and years of clinical experience than to recovery status.[584] "This underscores the need to consider traditional 12-Step clinicians as complex, flexible and heterogeneous and neither predictable nor closed-minded to other behavioral approaches."[585]

[581] Arfken, C.L., Agius, E., Dickson, M.W., Anderson, H.L., & Hegedus, A.M. (2005). Clinicians' beliefs and awareness of substance abuse treatments in research and non-research affiliated programs. *Journal of Drug Issues, 35*, 547-558.

[582] Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., McSherry, T., et al. (2002). Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers. *Journal of Substance Abuse Treatment*, *23*, 309-318.

[583] Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., McSherry, T., et al. (2002). Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers. *Journal of Substance Abuse Treatment*, *23*, 309-318.

[584] Forman, R.F., Bovasso, G., & Woody, G. (2001). Staff beliefs about addiction treatment. *Journal of Substance Abuse Treatment*, *21*, 1-9. Humphreys, K., Noke, J.M., & Moos, R.H. (1996). Recovering substance abuse staff members' beliefs and about addiction. *Journal of Substance Abuse Treatment*, *13*, 75-78. Knudsen, H.K., Ducharme, L.J., Roman, P.M., & Link, T. (2005). Buprenorphine diffusion: The attitudes of substance abuse treatment counselors. *Journal of Substance Abuse Treatment*, *29*, 95-106. Roman, P.M. & Johnson, J.A. (2002). Adoption and implementation of new technologies in substance abuse treatment. *Journal of Substance Abuse*, *22*, 211-218.

[585] McGovern, M.P., Fox, T.S., Xie, H., & Drake, R.E. (2004). A survey of clinical practices and readiness to adopt evidence-based practices: Dissemination research in an addiction treatment system. *Journal of Substance Abuse Treatment, 26*, 305-312.

- Attitudes toward evidence-based psychosocial interventions such as contingency management do not differ by recovery status alone.[586]
- Counselor attitudes concerning the acceptability and effectiveness of buprenorphine in the treatment of opiate dependency and naltrexone in the treatment of alcohol abuse and dependence do not vary by counselor recovery status,[587] but counselors in recovery express more negative attitudes toward the use of ibogaine in opioid dependency than do counselors not in recovery.[588]
- Counselor receptivity to the use of medications in addiction treatment is a function of education, training, and certification/licensure, rather than recovery status.[589]
- There is no direct linkage between counselor recovery status and support for or resistance to the implementation of evidence-based practices in addiction treatment.[590]

The studies reviewed here challenge the portrayal of addiction counselors in recovery as a monolithic group that supports a single pathway model of addiction, treatment, and recovery and resists the acquisition of new knowledge

---

[586] Kirby, K. C., Benishek, L. A., Dugosh, K. L., & Kerwin, M. E. (2006). Substance abuse treatment providers' beliefs and objections regarding contingency management: Implications for dissemination. *Journal of Substance Abuse Treatment, 85,* 19-27.

[587] Knudsen, H.K., Roman, P.M., Ducharme, L.J., & Johnson, J.A. (2005). Organizational predictors of pharmacological innovation adoption: The case of disulfiram. *Journal of Drug Issues*, *35*, 559-573. Thomas, S.E. & Miller, P.M. (2006). Knowledge and attitudes about pharmacotherapy for alcoholism: A survey of counselors and administrators in community-based addiction treatment centres. *Alcohol and Alcoholism*, *42*, 113-118.

[588] There are program differences that distinguish openness to naltrexone adoption, with treatment programs based on a 12-Step philosophy less inclined to use naltrexone, and physicians in recovery are less inclined to prescribe Naltrexone. Oser, C.B. & Roman, P.M. (2007). A categorical typology of naltrexone-adopting private substance abuse treatment centers. *Journal of Substance Abuse Treatment*, *34*(4), 433-442. Thomas, C.P., Wallack, S.S., Lee, S., McCarty, D., & Swift, R. (2003). *Journal of Substance Abuse Treatment*, *24*, 1-11. Rieckmann, T., Daley, M., Fuller, B.E., Thomas, C.P., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications for treatment of opioid dependence. *Journal of Substance Abuse Treatment*, *32*, 207-215.

[589] Fuller, B.E., Riechkmaan, T., McCarty, D., Smith, K.W., & Levine, H. (2005). Adoption of naltrexone to treat alcohol dependence. *Journal of Substance Abuse Treatment, 28*, 273-280. Knudsen, H.K., Roman, P.M., Ducharme, L.J., & Johnson, J.A. (2005). Organizational predictors of pharmacological innovation adoption: The case of disulfiram. *Journal of Drug Issues, 35,* 559-573.

[590] Kirby, K. C., Benishek, L. A., Dugosh, K. L., & Kerwin, M. E. (2006). Substance abuse treatment providers' beliefs and objections regarding contingency management: Implications for dissemination. *Journal of Substance Abuse Treatment, 85,* 19-27. Knudsen, H.K. & Roman, P.M. (2004). Modeling the use of innovations in private treatment organizations: The role of absorptive capacity. *Journal of Substance Abuse Treatment*, *26*, 353-361.

and skills.[591] The addiction treatment workforce scores high on readiness to adopt new counseling techniques that would improve recovery outcomes.[592]

Role Perceptions of Recovering Addiction Counselors

In the 1970s, Kozel and Brown[593] conducted a study of ex-addicts' and non-addict counselors' perceptions of their roles as counselors. The two groups shared a common vision of their role. The only noted difference was that ex-addicts perceived the ideal counseling role as involving greater amounts of time spent in community education, counseling in the community, and socializing with clients. Aiken and colleagues confirmed this finding a decade later.[594]

Recovery Status and Client Perception of Credibility and Effectiveness

Ball and colleagues[595] asked addicted clients in treatment to rate the degree of helpfulness of treatment staff. Forty-two percent of professional counselors were rated as helpful, while 60% of ex-addict counselors were rated as helpful. Another early study on counselor credibility focused on the addicts' ratings of various sources of information about drugs. Sinnett and colleagues[596] found that addicts felt that their own experience and that of ex-addicts (source ranking of 1 and 2) were far more credible sources of information than scientific journals (source ranking of 19) or psychologists, psychiatrists, or social workers (source rankings of 23, 25, and 30 respectively). LoSciuto and colleagues[597] found that clients favored ex-addicts on their knowledge of street drugs, but that

---

[591] Thombs, D.L. & Osborn, C.J. (2001). A cluster analytic study of clinical orientations among chemical dependency counselors. *Journal of Counseling and Development*, *79*, 450-458.

[592] Toriello, P.J., Roahen-Harrison, S., Rice, J., Ager, R., Morse, E.V., Morse, P., et al. (2005). The relationship between addictions counselors' clinical orientations and their readiness to change counseling techniques. *Journal of Addictive Diseases*, *24*(1)Supplement, 75-92.

[593] Kozel, N.J. & Brown, B.S. (1973). The counselor role as seen by ex-addict counselors, nonaddict counselors and significant others. *Journal of Consulting and Clinical Psychology*, *41*, 315.

[594] Aiken, L., LoSciuto, L., Ausetts, M., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Diverse routes to the same role. *International Journal of Addictions*, *19*(2), 153-73.

[595] Ball, J.C., Graff, H., & Sheehan, J.J., Jr. (1974). The heroin addict's view of methadone maintenance. *British Journal of the Addictions*, *69*(1), 89-95.

[596] Sinnett, E.R., Hagen K., & Harvey, W.M. (1975). Credibility of source of information about drugs to heroin addicts. *Psychological Reports*, *37*(3), 1239-1242. Sinnet, E.R., Press, A., Bates, R.A., & Harvey, W.M. (1975). Credibility of sources of information about drugs. *Psychological Reports*, *36*, 299-309.

[597] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

recovering counselors and counselors without a history of addiction achieved similarly high marks on other aspects of the counseling relationship.

Later studies of client perceptions of counselors concerning such factors as empathy, expertness, trustworthiness, and attractiveness do not generally show significant differences in these perceptions based on the recovery status of the counselor.[598] Berzins and Ross[599] looked at the helping preferences of 50 hospitalized female opiate addicts. While professionals and ex-addicts exerted similar attractiveness, patients with more severe addictions expressed preference for ex-addict helpers, and those with milder problem severity expressed preference for professionals. As one of the few studies that factored in problem severity, this study suggests that recovering helpers may have a special role engaging people with the most severe addiction problems and serving as a bridge for connection to professionals and the larger society they represent.

Professional training, regardless of recovery status, increases credibility in the eyes of clients.[600] But at least one study[601] found that recovering counselors were less likely than counselors without a history of addiction to believe they needed addiction education and training. When clients are asked to rate their perceptions of the value of ex-addict counselors, African American counselors and clients rate such value considerably higher than do other ethnic groups.[602] Savage and Stickles[603] compared the perceptions of three groups concerning whether recovering counselors or counselors without a history of

---

[598] Aiken, L.S. & LoSciuto, L.A. (1985). Ex-addict versus non-addict counselors' knowledge of clients' drug use. *International Journal of the Addictions*, *20*, 417-433. Ellis, K.P. (1995). Client perception of the therapist in drug treatment as a function of interpersonal skills and recovery status. Dissertation, United States International University. *Dissertation Abstracts International, 56*(08B), 4579. Johnson, M.E. & Prentice, D.G. (1990). Effects of counselor gender and drinking status on perceptions of the counselor. *Journal of Alcohol and Drug Education*, *35*, 38-44. Kirk, W.G., Best, J.B., & Irwin, P. (1986). The perception of empathy in alcoholism counselors. *Journal of Studies on Alcohol*, *47*, 82-84. Simmering, J.A. (1986). Effect of shared history of alcoholism on client perceptions of counselor characteristics. *Dissertation Abstracts International*, *47*(1), 87-A-88-A. Toriello, P.J. & Strohmer, D.C. (2004). Addictions counselors' credibility: The impact of interactional styles, recovery status, and nonverbal behavior. *Journal of Addictions and Offender Counseling*, *25*(1), 43-57.

[599] Berzins, J.I. & Ross, W.F. (1972). Experimental assessment of responsiveness of addict patients to the "influence" of professionals versus other addicts. *Journal of Abnormal Psychology*, *80*(November), 141-148.

[600] LoBello, S.G. (1984). Counselor credibility with alcoholics and non-alcoholics: It takes one to know one? *Journal of Alcohol and Drug Education*, *29*(2), 58-66.

[601] McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, *4*(1), 43-60.

[602] Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1987). Attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, *175*, 653-660. Nurco, D.N., Hanlon, T.E., Shaffer, J.W., Kinlock, T.W., Duszynski, K.R., & Stephenson, P. (1988). Differences among treatment clinic types in attitudes toward narcotic addiction. *Journal of Nervous and Mental Disorders*, *176*, 714-718.

[603] Savage, M. & Stickles, J. (1990). Adolescent and counselor preferences for recovering vs. non-recovering alcoholism counselors. *Journal of Adolescent Chemical Dependency*, *1*(2), 117–138.

alcoholism would provide the most effective assistance for alcohol problems. Both graduate students preparing to become counselors and practicing counselors expressed a preference for the recovering counselor (47% to 21%); 86% of high school students preferred the recovering counselor. Another interesting finding was that recovering alcoholics in AA perceived counselors in recovery more positively than did alcoholics initially seeking recovery, suggesting the potential utility of using recovering people for post-treatment recovery support services or for clinical work with AA members who have relapsed after some period of sobriety.[604] As a point of comparison, most program administrators who were surveyed in 1992 reported that recovering counselors and counselors without a history of addiction were equally effective.[605]

The mixed findings on this question of client-perceived credibility or preferences related to recovery status are similar to mixed findings from the general disability literature on whether persons with disabilities prefer working with counselors who share their disability. This literature, like studies of addiction recovery status, notes a preference for peer status or no finding of peer preference, but there are no studies noting that a shared disability would disqualify someone as an effective counselor.[606] White and Kurtz (2006)[607] have described three types of attitudes toward personal recovery—recovery-positive, recovery-neutral, and recovery-negative identities. The last of these categories embraces people who feel great shame attached to their addiction history and recovery status, reject the "disability identity," and seek to "pass" socially by rigorously hiding their recovery status. This raises at least the theoretical possibility that internalized stigma might lead these individuals to perceive an assigned helper in recovery as less credible and less effective. Such perceptions might contribute to increased resistance and weak therapeutic alliance.

COUNSELOR RECOVERY STATUS AND THERAPEUTIC ALLIANCE

Early studies presented conflicting findings on whether counselors' recovery histories bestowed heightened capacities for therapeutic alliance with clients entering addiction treatment. Talbott and Gillen[608] compared a group of recovering counselors to counselors with no addiction history and found that

---

[604] Priester, P.E., Azen, R. Speight, S., & Vera, E.M. (2007). The impact of counselor recovery status similarity on perceptions of attractiveness with members of Alcoholics Anonymous: An exception to the repulsion hypothesis. *Rehabilitation Counseling Bulletin, 51*, 14-20.

[605] Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596-603.

[606] Priester, P.E., Azen, R. Speight, S., & Vera, E.M. (2007). The impact of counselor recovery status similarity on perceptions of attractiveness with members of Alcoholics Anonymous: An exception to the repulsion hypothesis. *Rehabilitation Counseling Bulletin, 51*, 14-20.

[607] White, W. & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

[608] Talbott, J.A. & Gillen, C. (1978). Differences between nonprofessional recovering alcoholic counselors treating Bowery Alcoholics: A study of therapist variables. *Psychiatric Quarterly*, *50*(4), 333-342.

recovery status predicted neither a uniform set of counselor values nor uniform clinical outcomes (as measured by engagement and retention rates). In contrast, Lawson used the Barrett-Lennard Relationship Inventory to compare the scores of recovering counselors and counselors without a history of addiction and found that prior alcoholism recovery was "a significant factor in the quality of the relationship which existed between counselors and patients…".[609] Machell[610] conducted a study of the influence of a client's primary counselor's recovery status on the client's sense of belonging within the treatment milieu, length of stay in treatment, and post-treatment relapse rates. No differences by counselor recovery status were found. A similar lack of differences in perception of empathy and therapeutic alliance has been reported in other studies.[611]

Meier, Barrowclough, and Donmall conducted a recent literature review concerning therapeutic alliance in addiction treatment.[612] They concluded: "More experienced counselors were able to retain their clients in treatment for longer, and length of experience of delivering counseling appeared to be a more influential predictor than having a formal counseling qualification."[613] This is congruent with findings from the general disabilities literature indicating that a shared status with the client engenders a working relationship with the helpee only in the presence of at least a minimum level of helping skills.[614]

Sanders, Trinh, Sherman, and Banks[615] compared peer-led counseling groups with counseling groups led by addiction counselors. They found that clients with peer counselors were more likely to describe them as empathic and to identify them as the most helpful part of their treatment experience.

COUNSELOR RECOVERY STATUS AND ETHICAL DECISION-MAKING

Recovery status raises ethical issues within counseling, case management, and other service roles that are more complex than for helpers not in personal recovery—greater complexity in dual relationships, ambiguities

---

[609] Lawson, G. (1982). Relation of counselor traits to evaluation of the counseling relationship by alcoholics. *Journal of Studies on Alcohol*, *43*, 834-839, quotation from p. 836.

[610] Machell, D.F. (1991). Counselor substance abuse history, client fellowship, and alcoholism treatment outcome: A brief report. *Journal of Alcohol and Drug Education*, *37*(1), 25-30.

[611] Kirk, W.G., Best, J.B., & Irwin, P. (1986). The perception of empathy in alcoholism counselors. *Journal of Studies on Alcohol*, *47*, 82-84.

[612] Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction, 100,* 304-316.

[613] Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction, 100,* 304-316.

[614] Leierer, S.J., Strohmer, D.C., & Leclere, W.A. (1996). The effect of counselor disability, attending behavior, and client problem on counseling. *Rehabilitation Counseling Bulletin*, *40*, 82-90.

[615] Sanders, L. M., Trinh, C., Sherman, B. R., & Banks, S. M. (1998). Assessment of client satisfaction in a peer counseling substance abuse treatment program for pregnant and postpartum women. *Evaluation and Program Planning, 21*, 287-296.

related to self-disclosure, potential role conflict with other professionals, and confidentiality within service relationships and recovery community relationships.[616]

Torriello and Benshoff[617] evaluated the sensitivities of addiction counselors facing ethical dilemmas. In a surprising finding, those with an associate's degree or high school diploma (recovery status of the sample was not identified, but lower education continues to be a proxy for counselor recovery status in many treatment programs) exhibited greater ethical sensitivity than those with a graduate degree. Sias, Lambie, and Foster [618] studied the influence of recovery status on moral reasoning in addiction counselors. They found no differences between the moral reasoning abilities of recovering counselors and those of counselors without addiction histories. McCollum[619] compared recovering addiction counselors and addiction counselors without addiction histories regarding their beliefs about dual relationships. Counselors not in recovery found dual/multiple relationships more ethically problematic than did recovering counselors. This difference might be related to the fact that recovering counselors more frequently encounter clients in recovery support group meetings and have learned how to clearly define and separate these roles. This explanation draws some support from a study by Bachrach[620] that compared peer helpers within a union-based peer assistance program within the airline industry. The study found that peer helpers in recovery used more assertive relationship boundary management tactics than did peer helpers who were not in recovery.

The P-BRSS literature suggests three levels of intimacy in the helping relationship: 1) a zone of enmeshment marked by extreme directiveness, over-involvement, and possessiveness; 2) a zone of disengagement marked by coldness, passivity, and physical and emotional detachment; and 3) a zone of appropriateness and effectiveness marked by firmness, continuity of contact, and support that remains within the educational and experiential capabilities of the P-

---

[616] Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumers-providers: Barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199-213. White, W. & Popovits, R. (2001). *Critical incidents: Ethical issues in the prevention and treatment of addiction*. Bloomington, IL: Chestnut Health Systems. 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.

[617] Torriello, P.J. & Benshoff, J.J. (2003). Substance abuse counselors and ethical dilemmas: The influence of recovery and education level. *Journal of addictions and Offender Counseling*, *23*(2), 83-98.

[618] Sias, S.M, Lambie, G.W., & Foster, V.A. (2006). Conceptual and moral development of substance abuse counselors: Implications for training. *Journal of Addictions and Offender Counseling*, *26*(2), 99-110.

[619] McCollum. V. (2006). Beliefs of board certified substance abuse counselors regarding multiple relationships. *Journal of Mental Health Counseling, 28*, 84-94. Retrieved August 25, 2008 from http://www.thefreelibrary.com/Beliefs+of+board+certified+substance+abuse+counselors+regarding...-a0141212922.

[620] Bacharach, S. B. (2000). Boundary management tactics and logics of action: The case of peer-support providers. *Administrative Science Quarterly*, *45*, 704-736.

BRSS specialist.[621] The boundaries demarcating these zones are poorly defined, but there are ethical guidelines emerging to guide the delivery of P-BRSS that are based on recovery community values and collective experience as opposed to guidelines that simply mimic ethical standards for addiction counselors, psychologists, and social workers.[622]

Training of P-BRSS specialists emphasizes the importance of practicing within the boundaries of one's education, training, and experience, but some research has suggested that service providers at all levels of training consistently overestimate their skills.[623] The ethical mantra to practice within the boundaries of one's education, training, and experience has meaning only if professional and peer helpers accurately perceive their limitations and use supervisory structures to validate those perceptions.

Counselor Recovery Status and Client Satisfaction with Services

Mavis and Stöffelmayr[624] conducted a study of factors related to client satisfaction with addiction treatment. The clients in their study who were treated by recovering staff reported higher ratings of satisfaction with treatment than those treated by staff not in recovery. Ball, Graff, and Sheehan[625] conducted a study of heroin addicts' views of methadone maintenance treatment. Although ex-addicts filled only four of 44 staff positions, 60% of patients identified the ex-addict counselors as the most helpful part of their treatment experience.

Counselor Recovery Status and Client Recovery Outcomes

In comparing the clinical outcomes of addiction counselors, three preliminary points are noteworthy: 1) there are significant differences in outcomes across counselors, 2) counselor assignment accounts for greater degrees of variance in outcome than assignment to different treatment, and 3)

---

[621] Manohar, V. (1973). Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, *34*, 869-877. White, W. & Popovits, R. (2001). *Critical incidents: Ethical issues in the prevention and treatment of addiction.* Bloomington, IL: Chestnut Health Systems.

[622] Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumers-providers: Barriers and alternative solutions. *Community Mental Health Journal, 37*(3), 199-213. 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.

[623] Walters, S.T., Matson, S.A., Baer, J.S., & Ziedonis, D.M. (2005). Effectiveness of workshop training for psychosocial addiction treatments: A systematic review. *Journal of Substance Abuse Treatment, 29*, 283-293.

[624] Mavis, B.E. & Stoeffelmayr, B.E. (1994). Program factors influencing client satisfaction in alcohol treatment. *Journal of Substance Abuse*, *6*, 345-354.

[625] Ball, J.C., Graff, H., & Sheehan, J.J., Jr. (1974). The heroin addict's view of methadone maintenance. *British Journal of the Addictions*, *69*(1), 89-95.

differences in outcomes across counselors may be greater in the addictions field than in other areas of counseling.[626]

The earliest professional reports on client outcomes by helper recovery status were primarily observational.[627] Slaughter and Torno[628] described a peer-based counselor program in which senior patients were assigned to mentor incoming clients, lead groups, and even manage a treatment unit. Their reported outcomes included higher patient retention rates and greater insight of patients into their problems. Brown and Thompson[629] compared treatment outcomes for clients served by recovering counselors to outcomes for those served by counselors without a history of addiction. They concluded that recovery status did not enhance or detract from clinical outcomes as measured by rates of post-treatment drug use, employment, or arrest. A similar lack of recovery outcome differences by counselor recovery status was reported in studies by Valle;[630] LoSciuto, Aiken, and Ausetts;[631] Connet;[632] Longwell, Miller, and Nichols;[633] Moos, Finney, and Chan;[634] Machell;[635] and McLellan, Woody, Luborsky, and Goehl.[636]

What appear to be the most critical influences on recovery outcomes are not a counselor's recovery status or even formal education, but particular traits and the quality of addiction-specific counselor training and experience. These factors differ across counselors and are not predictable by recovery status of the

---

[626] Najavits, L. M., Crits-Christoph, P., & Dierberger, A. (2000). Clinicians' impact on the quality of substance use disorder treatment. *Substance Use and Misuse, 35*, 12-14. Najavits, L. M. & Weiss, R. D. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction, 89*, 679-688.

[627] Anderson, D. (1944). The place of the lay therapist in the treatment of alcoholics. *Quarterly Journal of Studies on Alcohol*, *5*, 257-266.

[628] Slaughter, L.D. & Torno, K. (1968). Hospitalized alcoholic patients. IV. The role of patient-counselors. *Hospital and Community Psychiatry*, *19*, 209.

[629] Brown, B. S. & Thompson, R. F. (1975). The effectiveness of formerly addicted and nonaddicted counselors on client functioning. *Drug Forum*, *5*(2), 123-129.

[630] Valle, S.K. (1977). Relative effectiveness of degreed and non-degreed alcoholism counselors. *Maryland State Medical Journal*, *26*(11), 12-14.

[631] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

[632] Connett, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, *15*(4), 585-589.

[633] Longwell, B., Miller, J., & Nichols, A.W. (1978). Counselor effectiveness in a methadone maintenance program. *The International Journal of the Addictions*, *13*(2), 307-315.

[634] Moos, R., Finney, J., & Chan, D. (1981). The process of recovery from alcoholism: 1. Comparing alcoholic patients and matched community controls. *Journal of Studies on Alcohol*, *42*, 383-402.

[635] Machell, D.F. (1991). Counselor substance abuse history, client fellowship, and alcoholism treatment outcome: A brief report. *Journal of Alcohol and Drug Education*, *37*(1), 25-30.

[636] McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation: An examination of treatment success among four counselors. *Journal of Nervous and Mental Disorders*, *176*(7), 423-430.

counselor.[637] Valle[638] conducted a study of the differences in client recovery rates assigned to eight recovering counselors. There were significant differences in client recovery outcomes across the counselors, with clients of recovering counselors with the highest levels of interpersonal functioning achieving the best post-treatment recovery rates (as measured by rates of continuous sobriety and number and duration of relapse episodes).

Seven studies identified in this review found at least slight differences in clinical outcomes by the recovery status of the counselors. All but one of these studies were conducted in the 1970s and 1980s. Argeriou and Maohar[639] found general equivalency of outcomes but found that younger clients had better recovery rates when assigned to recovering alcoholic counselors. Ottomanelli[640] compared the pre-treatment and post-treatment MMPI scales of clients assigned to professional and paraprofessional addiction counselors. There were no changes in pre/post MMPI scales for the clients of recovering counselors, but two of the post-treatment MMPI scales (the D and Sc scales) were lower for clients who had professional counselors—a finding limited by the small number of counselors in the study. LaRosa and colleagues randomly assigned clients in methadone treatment to group therapy conducted by master's-level therapists or ex-addict counselors. At one year follow-up, the professional therapists had retained more clients in treatment than the ex-addict counselors (68% versus 40%) and achieved higher satisfaction ratings.[641] Brown and colleagues[642] found that opiate clients had higher treatment retention rates when they were assigned professional rather than ex-addict counselors. Aiken and colleagues[643] found general equivalency between recovery rates of clients of recovering paraprofessionals, paraprofessionals without addiction histories, and professionals without addiction histories, but noted that clients counseled by professionals were more likely to pursue educational activities than were clients in the other two groups. King[644] found that alcoholics treated by recovering

---

[637] LoSciuto, L., Aiken, L.S., & Ausetts, M.A. (1979). *Professional and paraprofessional drug abuse counselors: Three reports* (NIDA Services Research Monograph Series DHSSS Publication No. ADM 81-858). Washington, DC: U.S. Government Printing Office.

[638] Valle, S. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol*, *42*, 783-790.

[639] Argeriou, M. & Monohar, V. (1978). Relative effectiveness of non-alcoholics and recovered alcoholics as counselors. *Journal of Studies on Alcohol, 39*, 793-799.

[640] Ottomanelli, G.A. (1978). Patient improvement, measured by the MMPI and Pyp, related to paraprofessional and professional counselor assignment. *International Journal of the Addictions*, *13*, 503-507.

[641] LaRosa, J.C., Lipsius, S.H. & LaRosa, J.H. (1974). Experiences with a combination of group therapy and methadone maintenance in the treatment of heroin addiction, *International Journal of the Addictions*, 9, 605-617

[642] Brown, B.S., Gfroerer, J., Thompson, P., & Berdine, A. (1985). Setting and counselor type as related to program retention. *International Journal of the Addictions*, *20*(5), 723-36.

[643] Aiken, L., LoSciuto, L., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: The progress of clients in treatment. *International Journal of Addictions*, *19*(4), 383-401.

[644] King, B.E. (1997). A comparison of sobriety success rates between alcoholic clients with recovering alcohol counselors vs. non-alcoholic counselors and metaphoric vs. non-

alcoholic counselors had higher post-treatment sobriety rates than did clients with counselors without recovery history. Snowden and Cotler (1974)[645] conducted an early study of the relationship between the personality characteristics of 25 paraprofessional ex-addict counselors working within a methadone program (as measured by the MMPI) and client outcomes (as measured by medication compliance, rates of attendance at counseling sessions, and negative urine tests). Counselors with personality traits usually regarded as "non-adjustive or even pathological" (e.g., concern with bodily functions, pervasive suspicion, hypersensitivity, emotional excitability as evidenced by enthusiasm or irritation) had higher client success rates. They concluded:

> *Perhaps most counselors, as newly reformed addicts of virtually equivalent duration, experience comparable amounts of personal distress. However, some are non-defensive or even overly prepared to acknowledge and explore these difficulties, while others deny the existence of such problems. Hence, the former group would probably be characterized by greater self-exploration, honesty, and openness to experience. These conditions have been related to therapeutic success*.[646]

This review confirms what folk wisdom in the field has long conveyed:

> *Addiction recovery can be a valuable asset to the helping process only when other conditions are met. Addiction recovery is by no means a necessary and sufficient criterion for counseling success*.[647]

This folk wisdom was again empirically confirmed in a study of therapist effects on clinical outcomes in Project MATCH (1998b),[648] which found significant therapist effects on outcomes, but these effects were unrelated to recovery status.

> *Client outcomes were unrelated to therapists' self-reports of being "alcoholic," having had alcohol problems, or being "in recovery." This is consistent with a large literature showing that a therapist's personal*

---

metaphoric counseling. Dissertation, Texas A&M University-Kingsville. *Dissertation Abstracts International*, *59*(05B), 2156.

[645] Snowden, L. & Cotler, S. (1974). The effectiveness of paraprofessional ex-addict counselors in a methadone treatment program. *Psychotherapy: Theory, Research & Practice*, *11*(4), 331-338.

[646] Snowden, L. & Cotler, S. (1974). The effectiveness of paraprofessional ex-addict counselors in a methadone treatment program. *Psychotherapy: Theory, Research & Practice*, *11*(4), 331-338.

[647] Wolf, S. (1983). Criteria for effectiveness: Recovered professionals as counselors. *Focus on Alcohol and Drug Issues*, *6*(3), 22, 28.

[648] Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, *8*, 455-474.

history of alcoholism and recovery neither benefits nor hinders his or her effectiveness in the treatment of substance abuse.[649]

Stöffelmayr and colleagues raised a provocative question related to the findings we have just reviewed:

> *…if professionals and paraprofessionals are equally effective* [in addiction counseling] *and cannot be differentiated in their approach to clients, why all these efforts to train paraprofessionals in the image of the professional counselor?*[650]

The above findings and conclusions are based on experience with recovering people working in specialty sector addiction treatment programs serving adults. They may or may not apply to the effectiveness of recovering people working as addiction counselors in adolescent treatment programs. Only one early (1978) study was located that specifically addressed this question. DeAngelis and Ross reported on a study conducted at Pride House, a therapeutic community for adolescents that was transitioning from a predominately ex-addict staff to a professional staff. Concerning the comparison of performance of ex-addict professionals and non-addict professionals, DeAngelis and Ross noted the following findings.

- Ex-addict professionals had longer tenures of employment and lower turnover than did non-addict professionals.
- Eight percent of non-addict professionals and 46% of ex-addict professionals who left Pride House were discharged for unethical conduct.
- There were no significant differences in client retention rates between the ex-addict and non-addict professionals.
- Non-addict professionals averaged 11 more client contacts per month than did ex-addict professionals.[651]

There were no reports of post-treatment recovery outcome based on client assignment to ex-addict or non-addict professional. The extent to which finding in the DeAngelis and Ross study are unique to this program, or to that era of addiction counseling, is unknown due to the lack of other studies.

---

[649] McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation: An examination of treatment success among four counselors. *Journal of Nervous and Mental Disorders*, *176*(7), 423-430. Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, *8*, 455-474.

[650] Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, *31*(2), 121-127, quote from page 127.

[651] De Angelis, G.G. & Ross, E.A. (1978). A comparison of nonaddict and ex-addict professionals in an adolescent treatment program. *Drug and Alcohol Dependence*, 3(5), 319-329.

Recovery Status and General Job Performance Factors

Blum and Roman[652] conducted a comparison of recovering occupational alcoholism consultants (OPCs) and OPCs without a history of addiction. They found substantial similarity between the two groups, with no differences found related to effectiveness of job performance. Recovering OPCs did report higher levels of job commitment and job satisfaction. Aiken and LoSciuto[653] conducted a study to evaluate counselor knowledge of drug use by their clients. Recovering staff were more accurate in identifying drug use of their clients than were non-addict counselors.

Vulnerability to Relapse among Counselors in Recovery

In the professional literature on addiction counseling there are innumerable references to the risk of relapse for recovering counselors, but few studies have measured the actual prevalence of counselor relapse. Rhodes and White[654] reported on 274 ex-addicts hired to fill multiple roles in the Illinois Drug Abuse Program between 1968 and 1973. They reported that 48% of this group had "failed" and that failure most frequently involved a return to drug use (six subsequent drug-related deaths were reported in this sample). It should be noted that this high failure and relapse rate occurred at a time when the emerging drug abuse treatment field knew little about the screening, hiring, orientation, training, and supervision of ex-addicts in helping roles.

Ten years later Kinney[655] conducted a 10-year follow-up of recovered alcoholics completing an alcoholism counselor training program. In that study, 37.5% of the graduates reported having experienced a relapse during the 10-year period. This is consistent with a survey of treatment programs in 1992, in which 39% of administrators reported that their agencies had experienced the relapse of an employee in recovery.[656] The same year, Kahn and Fau conducted a similar study of 145 recovering alcoholics trained to become alcoholism counselors (in successive classes over a 10-year period).[657] Only 4.8% of those training graduates reported having relapsed since completion of the training.

---

[652] Blum, T. & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors. *Journal of Health and Social Behavior*, *26*(4), 365-378.

[653] Aiken, L.S. & LoSciuto, L.A. (1985). Ex-addict versus non-addict counselors' knowledge of clients' drug use. *International Journal of the Addictions*, *20*, 417-433.

[654] Rhodes, C. & White, C., with Kohler, M.F. (1974). The role of the so-called paraprofessional in the six years of IDAP. In E. Senay, V. Shorty, & H. Alksne (Eds.), *Developments in the field of drug abuse* (pp. 1051-1066). Cambridge, MA: Schenkman.

[655] Kinney, J. (1983). Relapse among alcoholics who are alcoholism counselors. *Journal of Studies on Alcohol, 44*(4), 744-748.

[656] Anderson, S.C. & Wiemer, L.E. (1992). Administrators' beliefs about the relative competence of recovering and nonrecovering chemical dependency counselors. *Families in Society: The Journal of Contemporary Human Services*, *73*, 596-603.

[657] Kahn, M.W. & Fua, C. (1992). Counselor training as a treatment for alcoholism: The helper therapy principle in action. *The International Journal of Social Psychiatry 38*, 208-214.

This replicated findings from an earlier study of Kahn and Fau[658] in which only four of 25 alcoholics training as alcoholism counselors experienced a brief relapse after the training, but all had at least a year of sobriety at the follow-up evaluation.

The differences among these studies reflect, in part, a longer period of study in which the Kinney subjects might have relapsed and the years of history reflected in the Anderson and Wiemer study of treatment administrators, compared to the Kahn and Fau sample that included recent graduates.

Seen as a whole, these studies suggest that the risk of relapse among addiction counselors in recovery progressively declined between the 1960s and 1990s, probably as a function of increased role clarity as well as improved screening, selection, orientation, training, and supervision. Substance-related impairment continues to be a concern for addiction counselors. In a national survey of addiction counselor certification boards, 40 boards representing more than 32,900 certified addiction counselors reported a total of 373 ethical complaints during the years 1991 and 1992. Forty-six (12.4%) of those complaints were related either to impairment from substance use or to psychiatric impairment.[659] The portion of these cases that resulted in relapse of a recovering counselor (as opposed to a new substance use disorder of a counselor not previously in recovery) or to the development of mental health problems among counselors is unknown.

Influence of Recovery Status on Supervisory Relationships

There are only two studies that focus on the effects of the recovery status of the supervisor on supervisory relationships with addiction counselors of varied recovery status. Culbreth and Borders[660] found that a positive and supportive attitude was more important than recovery status in influencing the supervisory relationship. There were no differences in satisfaction with supervision based on recovery status of the supervisee and supervisor, but both recovering counselors and counselors without histories of addiction noted the potential for mismatches in which the supervisor discounted the professional or personal recovery experience of the counselor based on whether or not the supervisor had a history of addiction recovery.

In a follow-up study examining the content of supervision based on recovery status of the supervisor and supervisee, Culbreth[661] found that recovery status of the counselor did influence the topical focus of supervision, with

---

[658] Kahn M.W. & Fua, C. (1985). Counselor training as a therapy for alcohol abuse among aboriginal people. *American Journal of Community Psychology*, *3*(5), 613-616.

[659] St. Germaine, J. (1997). Ethical practices of certified addiction counselors: A national survey of state certification boards. *Alcoholism Treatment Quarterly*, *15*, 63-72.

[660] Culbreth, J.R. & Borders, L.D. (1998). Perceptions of the supervisory relationships: A preliminary qualitative study of recovering and nonrecovering substance abuse counselors. *Journal of Substance Abuse Treatment*, *15*(4), 345-352.

[661] Culbreth, J. R. (1999). Clinical supervision of substance abuse counselors: Current and preferred practices. *Journal of Addictions and Offender Counseling, 20*, 15-25.

recovering counselors preferring more supervisory time focused on client typologies, ethical/legal issues, and personal/professional support.

EVALUATION OF TREATMENT MODELS STAFFED BY RECOVERING PEOPLE

Scientific studies have been conducted of four treatment/recovery models that rely almost exclusively on recovering people as helping agents: social model alcoholism programs, early ex-addict-directed therapeutic communities, early Minnesota Model chemical dependency programs, and the Twelve Step Facilitation arm of Project MATCH.

Social models of alcoholism recovery grew out of experiments with "AA farms" and "AA retreats" in the 1940s and 1950s.[662] Social model programs (SMPs) provide support for people voluntarily seeking recovery from alcoholism in a home-like, democratically governed residential environment that emphasizes the principles and practices of Alcoholics Anonymous. SMPs help people construct a sobriety-based social network that includes AA members and program alumni. SMPs are staffed by people whose authority is based on personal recovery experience rather than professional education and training. The primary catalyst for recovery is the relationship between the person and a community of recovering people, rather than the relationship between a client and a therapist. Learning about recovery occurs through modeling and discussion rather than through didactic instruction, and relationships between SMP staff and participants/residents (not clients or patients) are egalitarian rather than hierarchical. Responsibility for initiating and sustaining sobriety is the responsibility of each participant who draws support from his or her peers in recovery. SMPs rely on client-centered recovery planning rather than on staff-directed treatment planning.[663]

A review of early evaluations of SMPs reported sustained abstinence in 33% of participants and reduced substance use in 21% of participants. These evaluations also reported enhanced employment and family incomes and reductions in criminal activity comparable to those achieved in clinical models of treatment, but at dramatically reduced costs.[664] A recent and methodologically

---

[662] See White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[663] Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42. Borkman, T., Kaskutas, L.A., & Barrows, D.C. (1996). *The social model program: A literature review and history*. Rockville, MD: Center for Substance Abuse Treatment. Borkman, T. J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, *15*(1), 7-17. Wright, A. (1991). What is social model? In S. Shaw & T. Borkman (Eds.), *Social model alcohol recovery: An environmental approach* (pp. 7-10). Burbank, CA: Bridge Focus, Inc.

[664] Borkman, T. J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, *15*(1), 7-17.

rigorous study[665] compared recovery outcomes in social and non-social model programs. At one-year follow-up, more clients treated in social model programs reported an absence of alcohol problems than did clients treated in clinical programs (57% to 49%), and a greater percentage also reported having no drug problems (59% to 51%). Other outcomes, such as reported medical, psychiatric, and family problems, were similar across program type. The reported effects of the social model programs may be mediated by levels of AA and NA participation that were higher at follow-up than the levels of such participation among clients treated in clinical programs.

Evaluations of fidelity to the core elements of the SMP reveal considerable fidelity erosion over time. Three factors contribute to the erosion of this model: 1) funding policies that do not reimburse key elements of the social model, 2) regulatory requirements that force a more institutional and less home-like environment, and 3) the professionalization of the SMP peer support relationship.[666]

The Minnesota Model (MM) of chemical dependency treatment, like social model programs, began as a peer-based approach to alcoholism recovery.[667] It then evolved through several stages that included delivery of services via a multidisciplinary team and the subsequent professionalization of the role of the alcoholism counselor within that team.[668] Today's chemical dependency counselor within the MM is less likely to be in recovery and, if in recovery, is more likely to have a college or post-graduate degree in a counseling-related field as well. Today, the 12-Step philosophy that was once the centerpiece of the MM is more likely to be presented alongside multiple philosophies and approaches. As a result, clients treated within these programs today are less likely to receive the intense exposure to recovering alumni, AA volunteers, and AA meetings in the community than was the norm decades ago. In light of all these changes, the earliest evaluations of the MM (those prior to 1980), although methodologically weaker than later studies, may give a more accurate evaluation of the influence of peer-based recovery support.

Rossi, Stach, and Bradley[669] conducted the first detailed MM follow-up study of patients admitted to Willmar State Hospital (mean follow-up period of over 21 months) and reported that 24% of patients had been abstinent for six months or more prior to follow-up, and 14% had been abstinent since discharge. Laundergan[670] evaluated clients discharged from Hazelden between 1973 and 1975, and reported that 50% were abstinent at follow-up (57.1% adjusted for

---

[665] Kaskutas, L. A., Ammon, L. N., & Weisner, C. (2003-4). A naturalistic analysis comparing outcomes of substance abuse treatment programs with different philosophies: Social and clinical model perspectives. *International Journal of Self Help and Self Care*, *2*, 111-133.

[666] Kaskutas, L. A., Keller, J. W., & Witbrodt, J. (1999). Measuring social model in California: How much has changed? *Contemporary Drug Problems, 26*, 607-631.

[667] This refers to the early recovery models at Pioneer House and Hazelden in the late 1940s.

[668] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[669] Rossi, J., Stach, A., & Bradley, N. (1963). Effects of treatment of male alcoholics in a mental hospital: A follow-up study. *Quarterly Journal of Studies on Alcohol, 24*, 91-108.

[670] Laundergan, J. (1982). *Easy does it: Alcoholism treatment outcomes, Hazelden and the Minnesota Model*. Center City, Minnesota: Hazelden Foundation.

non-response, deaths, and treatment re-entry) and 17.6% were improved—defined as drinking at the time of follow-up but at levels lower than pre-treatment levels. Cook[671] reviewed outcome studies for MM programs from this period and concluded: "Despite exaggerated claims of success, it [the Minnesota Model] appears to have a genuinely impressive 'track record' with as many as two-thirds of its patients achieving a 'good' outcome at 1 year after discharge."[672]

The therapeutic community (TC), although considerably different from social model and Minnesota Model programs,[673] also underwent changes that decreased its peer orientation. These changes include the professionalization of staff and the subsequent shift in relational status from "brothers" and "sisters" living and learning together within the TC "family" to "clients" being "treated" by professional staff. TCs have also shifted from an exclusive reliance on peer-support from inside the TC to the integration of involvement in 12-Step groups in the local community. In the TC world, "peer" now extends to people beyond the TC community.

De Leon[674] reviewed the early TC effectiveness data and reported consistent positive outcomes, including post-treatment decreases in drug use and criminality and increases in employment and other indices of social adjustment. Two limitations to these findings are critical. First, positive outcomes were directly related to dose of treatment, with 120-180 days being the minimum dose for positive outcomes. Second, only 10-20% of people admitted to TCs successfully completed all phases of treatment. For example, early studies of Phoenix House revealed very high dropout rates (between 71-78%), but there were also high rates of sustained abstinence for those completing the TC program (94% at 12 months following completion).[675] More than 60% of early TC graduates assumed staff positions within the TC in which they had graduated

---

[671] Cook, C. (1988a). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part I. Philosophy and the programme. *British Journal of Addiction, 83*, 625-34. Cook, C. (1988b). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part II. Evidence and conclusions. *British Journal of Addiction*, *83*, 735-748.

[672] In a later one-year follow-up study of more than 1,000 Hazelden graduates, 53% reported continuous abstinence since discharge, and 35% had reduced their alcohol and drug use. Stinchfield, R. & Owen, P. (1998). Hazelden's model of treatment and its outcome. *Addictive Behaviors*, *23*(5), 669-683. Cook, C. (1988b). The Minnesota model in the management of drug and alcohol dependency: Miracle, method or myth? Part II. Evidence and conclusions. *British Journal of Addiction*, *83*, 735-748.

[673] Borkman, T., Kaskutas, L.A., & Owen, P. (2007). Contrasting and converging philosophies of three models of alcohol/other drugs treatment: Minnesota model, social model and addiction therapeutic communities. *Alcoholism Treatment Quarterly*, *25*(3), 21-38.

[674] De Leon G. (1984). *The therapeutic community: Study of effectiveness* (NIDA Treatment Research Monograph Series, DHHS Publication (ADM) 85-1286). Rockville, MD: National Institute on Drug Abuse.

[675] De Leon, G., Holland, S., & Rosenthal, M.S. (1972). Therapeutic community for drug addicts, long-term measurement of emotional changes. *Psychological Reports*, *29*, 595-600. Nash, G. Waldorf, D., Foster, K., & Kyllingstad, A. (1974). The Phoenix House program: The results of a two year follow-up. In G. De Leon (Ed.), *Phoenix House: Studies in a therapeutic community (1968-1973)*. New York: MSS Information.

or in a similar program[676]—a finding that triggered concern that ex-addict staff may not be well equipped to guide clients' community reintegration.[677]

Social model programs, Minnesota Model programs, and therapeutic communities all became less peer oriented over time, due to trends in the broader field of addiction treatment. These trends included professionalization, regulation (and its accompanying paperwork burdens), commercialization, the shift in preference from inpatient/residential to outpatient treatment modalities, and the shortened treatment duration that has been a result of managed behavioral health care.[678] Those changes set the stage for the re-emergence of more purely peer-based recovery models such as recovery homes, the growth of recovery community centers, the role of the recovery coach, and other peer-support specialty roles.

Project MATCH was a multi-site (nine treatment units), randomized trial to evaluate the benefits of matching clients who meet diagnostic criteria for alcohol abuse or alcohol dependence to three different specialized treatments. The three treatments included Cognitive Behavioral Coping Skills (CBT), Motivational Enhancement Therapy (MET), and Twelve-Step Facilitation (TSF). All were delivered over a 12-week period either as outpatient treatment or as an aftercare intervention following completion of inpatient or intensive day-hospital treatment.

Key findings of the Project MATCH study included sustained reductions in drinking among clients in all three treatments and the lack of clear superiority of one treatment over another. Findings related to matching variables were few: clients low in psychiatric severity who participated in TSF achieved better abstinence outcomes at one-year follow-up than did those who participated in CBT.[679] The superiority of TSF over CBT on abstinence outcomes continued at year three follow-up.[680]

The relevance of this finding to our current discussion is that TSF focused on promoting acceptance of alcoholism as a disease and on fostering a commitment to participate in Alcoholics Anonymous and AA "step work," and was delivered primarily by therapists in 12-Step recovery from alcoholism who were also masters-trained and/or state-certified alcoholism counselors.[681] The superior outcomes of the TSF intervention appear to be related to increased

---

[676] Scott, D. & Goldberg, H.L. (1973). The phenomenon of self-perpetuation in Synanon-type drug treatment programs. *Hospital and Community Psychiatry*, *24*, 231-233.

[677] Brown, B.S. (1979). *Addicts and aftercare: Community integration of the former drug user.* Beverly Hills: SAGE Publications.

[678] Borkman, T., Kaskutas, L.A., & Owen, P. (2007). Contrasting and converging philosophies of three models of alcohol/other drugs treatment: Minnesota model, social model and addiction therapeutic communities. *Alcoholism Treatment Quarterly*, *25*(3), 21-38.

[679] Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

[680] Project MATCH Research Group. (1998a). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research*, *22*(6), 1300-1311.

[681] Carroll, K. M., Kadden, R. M., Donovan, D. M., Zweben, A., & Rounsaville, B. J. (1994). Implementing treatment and protecting the validity of the independent variable in treatment matching studies. *Journal of Studies on Alcohol, Supplement 12*, 149-155.

levels of post-treatment AA participation. Reports of client satisfaction and post-treatment drinking outcomes were not related to counselor recovery status.[682]

Evaluation of Recovery Volunteer Programs Linked to Addiction Treatment or Medical Treatment

Volunteer programs were very popular within addiction treatment in the mid-1970s, but a review of the literature on volunteer programs conducted in 1980 found no studies evaluating the effects of volunteer support on client recovery outcomes[683] The broader evaluation of such programs revealed consistently positive responses regarding the role of volunteers in general and the role of indigenous volunteers in recovery.[684] Typical of these early evaluations was that conducted by Manohar,[685] which found that a volunteer program within the Alcoholism Division of Boston City Hospital eliminated the waiting list for services, increased patient retention, and enhanced continuity of care following discharge. Volunteers in recovery with more than one year of sobriety at this site were more likely to establish relationships with patients characterized by warmth and non-possessiveness than were those with less sobriety or who were not in recovery.

There are more recent evaluations of volunteer programs within the addiction services arena. Blondell and colleagues[686] compared patients hospitalized for alcohol-related trauma who were randomly assigned to care as usual, a brief 5-to-15-minute physician intervention, or a 30-to-60-minute meeting with a recovering alcoholic (AA) volunteer. Those in the peer intervention had superior outcomes at 6-month follow-up (64% abstinence rate compared to 36% and 51% for the other interventions, and a 49% rate of treatment initiation or recovery support group involvement following discharge compared to 9% and 15% for the other two interventions). The investigators concluded that, in addition to their effectiveness, visits by AA volunteers to hospitalized patients were "simple, practical, involve no costs, and pose little patient risks."[687]

---

[682] Project MATCH Research Group. (1998b). Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, *8*, 455-474.

[683] Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

[684] Ausetts, M.A., LoSciuto, L.A., & Aiken, L.S. (1980). *The use of volunteers in drug abuse services: A review of the literature* (DHHS Publication No. (ADM) 80-1020). Rockville, MD: National Institute on Drug Abuse.

[685] Manohar, V. (1973). Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, *34*, 869-877.

[686] Blondell, R.D. Looney, S.W., Northington, A.P., Lasch, M.E., Rhodes, S.B., & McDaniels, R.L. (2001). Can recovering alcoholics help hospitalized patients with alcohol problems? *Journal of Family Practice*, *50*(5), 447.

[687] Blondell, R.D. Looney, S.W., Northington, A.P., Lasch, M.E., Rhodes, S.B., & McDaniels, R.L. (2001). Can recovering alcoholics help hospitalized patients with alcohol problems? *Journal of Family Practice*, *50*(5), 447.

Fagan[688] and Fagan and Mauss[689] evaluated a rehabilitation program for Skid Row alcoholics that achieved a 50% abstinence rate at follow-up from treatment. The program included teams of volunteers that "sponsored" each client's social re-entry. The volunteers were recruited primarily from local churches, but the study did not report the recovery representation within the volunteer teams. The duties and responsibilities of the volunteer "sponsors" are listed here because of their similarity to the emerging recovery coach role: "Assist a recovering skid-row alcoholic…in relocating, bettering his or her employment, housing, and social status through moral support, acceptance, advice, shared experiences, advocacy, and reflection on problems, solutions, and personal strengths."[690]

There is also a larger body of research on the effects of volunteering on the volunteer. Such studies report enhancements in physical health, confidence, self-worth, and life satisfaction, as well as reduced depression and anxiety, as predictable outcomes of volunteer activity.[691] There are no specific studies of the effects of volunteer activities outside of sponsorship roles on the health of people in recovery. Studies of sponsorship[692] would suggest that broader service activities might well enhance recovery outcomes, and studies of recovery volunteer programs have reported exceptionally high recovery stability rates of volunteers.[693]

Although no formal evaluations of the characteristics essential for effective volunteer recovery support work have been conducted, Manohar describes such characteristics as: "*(1) at least a high school education; (2) interest and experience in community service; (3) an authoritative rather than authoritarian approach; (4) a high degree of personal arousal* [energy]; *(5) ability to see alcoholism as a legitimate human experience; (6) acceptance of responsibility for helping others; (7) resilient, empathetic, self-confident and sensitive personalities; (8) to be able to say 'I don't know' with relative ease; and (9) to be able to react positively to the job, and to peers, supervisors and administrators*."[694]

---

[688] Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, *16*(3), 321-337.

[689] Fagan, R. & Mauss, A. (1986). Social margin and social reentry: An evaluation of a rehabilitation program for skid row alcoholics. *Journal of Studies on Alcohol, 47*, 413-425.

[690] Fagan, R.W. (1986). The use of volunteer sponsors in the rehabilitation of skid-row alcoholics. *Journal of Drug Issues*, *16*(3), 321-337, quote from page 323.

[691] Thoits, P. A. & Hewitt, L. N. (2001). Volunteer work and well being. *Journal of Health and Social Behavior*, *42*, 115-131.

[692] Crape, B.L., Latkin, C.A., Laris, A.S., & Knowlton, A.R. (2002). The effects of sponsorship in 12-Step treatment of injection drug users. *Drug and Alcohol Dependence*, *65*, 291-301. Cross, G.M., Morgan, C.W., Mooney, A.J., Martin, C.A., & Rafter, J.A. (1990). Alcoholism treatment: A ten-year follow-up study. *Alcoholism: Clinical and Experimental Research*, *14*, 169-173. Zemore, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal*, *100*(4), 447-450.

[693] Klein, R.F., Foucek, S.M., & Hunter, S.D. (1991). Recovering alcoholics as patient instructors in medical education. *Substance Abuse*, *12*(2), 82-89.

[694] Manohar, V. (1973). Training volunteers as alcoholism treatment counselors. *Quarterly Journal of Studies on Alcohol*, *34*, 869-877, quotation from page 871.

Collins, Barth, and Zrimec[695] conducted a positive evaluation of the effects of the use of recovering alcoholic volunteers within the alcoholism program at Cleveland Metropolitan General Hospital. In this program, more than 70 local AA volunteers from 14 AA groups operated a friendship room close to the emergency room of the hospital. The volunteers provided lay counseling, escort to AA meetings, guidance in obtaining sponsors, and post-discharge follow-up.[696] Collins and colleagues did note occasional problems arising within the volunteer program.

> *Among the problems we have encountered are volunteers undermining or attacking the professional treatment program, volunteers becoming angry or impatient with resistant patients, volunteers allowing outsiders…to hang around the Friendship Room as if it were a drop-in center, volunteers demanding treatment for inappropriate candidates, or (rarely) volunteers relapsing to drinking*.[697]

Collins and colleagues go on to note that such problems worked themselves out over the course of the program's first five years and that the keys to program success were staff attitude toward volunteers and giving the volunteers "ownership" of the program.

Relevant Studies on Peer-based Services from Allied Fields

The potential effectiveness of peer-based services draws further support from other fields of health and human services. Durlack[698] and Hattie[699] conducted evaluations of studies comparing the effectiveness of professional and paraprofessional counselors. In Durlack's review of 42 studies, one study found greater effectiveness among professional therapists (post-baccalaureate training in psychiatry, psychology, social work, or psychiatric nursing), and 12 studies found greater effectiveness among paraprofessional counselors (those without post-baccalaureate training), with the remaining studies finding no differences between professional and paraprofessional counselors. Durlack concluded:

> *Findings from 42 studies comparing the helping effectiveness of paraprofessionals and professionals are consistent and provocative. The*

---

[695] Collins, G.B., Barth, J., & Zrimec, G. (1980). Recruiting and retaining AA volunteers in a hospital alcoholism program. *Hospital and Community Psychiatry*, *32*(2), 130-132.

[696] Collins, G.B. & Barth, J. (1979). Using the resources of AA in treating alcoholics in a general hospital. *Hospital and Community Psychiatry*, *30*(7), 480-482.

[697] Collins, G.B., Barth, J., & Zrimec, G. (1980). Recruiting and retaining AA volunteers in a hospital alcoholism program. *Hospital and Community Psychiatry*, *32*(2), 130-132, quote from page 131.

[698] Durlak, J.A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin*, *86*(1), 80-92.

[699] Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, *95*(3), 534-541.

clinical outcomes paraprofessionals achieve are equal to or significantly better than those obtained by professionals.[700]

However, Durlack's 1979 review found only partial experimental evidence supporting the proposition that "indigenous therapists" (those similar to clients in background, lifestyle, and characteristics) generated better outcomes than did therapists who did not share such qualities with their clients. The proposition that counselors who shared their clients' culture and peer-level status would make more effective helpers[701] has been subsequently tested using multiple dimensions (race, gender, and religious orientation), with mixed findings.[702] The extent to which similarities in race, gender, age, religious orientation, drug choice, and recovery pathways between P-BRSS specialists and those they serve remains an important research question. (See discussion in Chapter Eight.)

Hattie's 1984 review of the comparative effectiveness of paraprofessional and professional helpers concluded:

> *Effect sizes based on 154 comparisons from 39 studies indicated that clients who seek help from paraprofessionals are more likely to achieve resolution of their problems than those who consult professionals….The more experienced the paraprofessionals, the greater their effectiveness compared to professionals*.[703]

The mental health field has used peers primarily in the role of case managers.[704] Solomon and Draine[705] reviewed studies comparing mental health consumer- and non-consumer-delivered case management services. They concluded that personal characteristics of the case manager, more than personal recovery history, influenced service outcomes. Other studies of peer-delivered mental health services found that consumers are well integrated into mental health service teams and achieve service outcomes equivalent to those delivered

---

[700] Durlak, J.A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin*, *86*(1), 80-92, quote from page 89.

[701] Pearl, A. (1981). The paraprofessional in human service. In S. Robbin & W. Wagonfeld (Eds.), *Paraprofessionals in the human services.* New York: Human Science Press.

[702] Atkinson. D.R., Maruyama, M., & Matsui, S. (1978). Effects of counselor race and counseling approach on Asian Americans' perception of counselor credibility and utility. *Journal of Counseling Psychology*, *25*, 76-83.

[703] Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, *95*(3), 534-541, quote from pages 534, 540.

[704] Mowbray, C. T., Moxley, D. P., Jasper, C. A., & Howell, L. L. (1997). *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services (IAPSRS).

[705] Solomon, P. & Draine, J. (1994). Family perceptions of consumers as case managers. *Community Mental Health Journal*, *30*(2), 165-76. Solomon, P. & Draine, J. (1994). Satisfaction with mental health treatment in a randomized trial of consumer case management. *Journal of Nervous and Mental Disorders*, *182*(3), 179-84.

by professionals.[706] Consumer-delivered mental health services are also linked to higher levels of positive regard and understanding,[707] greater contact with clients,[708] and higher rates of service retention and participation.[709] No differences in stress or burnout have been found in studies comparing consumer- and non-consumer-delivered mental health services.[710] In a recent review of this literature, Davidson and colleagues reviewed the available studies on consumer-run mental health services and concluded: "Consumer-run services can be viable organizations and can provide useful services."[711]

Peer-based services have also been positively evaluated in serving HIV+ addicted women,[712] as well as addicted women with a history of neglect of their children.[713] Until studies of new P-BRSS specialists' roles can be conducted, it may be necessary to rely on existing studies that have evaluated particular functions (outreach, case management, and advocacy) within these specialist roles.[714]

---

[706] Chinman, M.J., Rosenheck, R., Lam, J.A., & Davidson, L. (2000). Comparing consumer and nonconsumer provided case management services for homeless persons with serious mental illness. *Journal of Nervous and Mental Disorders, 188*(7), 446-53. Felton, C.J., Stastny, P., Shern, D.L., Blanch, A., Donahue, S.A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: impact on client outcomes. *Psychiatric Services*, *46*(10), 1037-44.

[707] Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric Services*, *57*(8), 1179-84.

[708] Solomon, P. &, Draine, J. (1996). Perspectives concerning consumers as case managers. *Community Mental Health Journal*, *32*(1), 41-6.

[709] Dermatis, H., Galanter, M., Trujillo, M., Rahman-Dujarric, C., Ramaglia, K. & LaGressa, D. (2006). Evaluation of a model for the treatment of combined mental illness and substance abuse: The Bellevue model for peer-led treatment in systems change. *Journal of Addictive Diseases*, *25*(3), 69-78.

[710] Solomon, P. &, Draine, J. (1996). Perspectives concerning consumers as case managers. *Community Mental Health Journal*, *32*(1), 41-6.

[711] Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, *6*(2), 165-187. In L. Davidson, C. Harding, & L. Spaniol, (Eds.) (2005). *Recovery from severe mental illness: Research evidence and implications for practice* (pp. 412-450). Boston: Boston University. Quote from page 172.

[712] Boyd, M.R., Moneyham, L., Murdaugh, C., Phillips, K.D., Tavakoli, A., Jackwon, K., et al. (2005). A peer-based substance abuse intervention for HIV+ rural women: A pilot study. *Archives of Psychiatric Nursing*, *19*(1), 10-17.

[713] Ryan, J. P., Marsh, J. C., Testa, M. F., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services. *Social Work Research*, *30*(2), 95-107.

[714] Studies evaluating these elements include: Cox, G. B., Walker, R. D., Freng, S. A., Short, B. A., Meijer, L. & Gilchrist, L. (1998). Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates. *Journal of Studies on Alcohol*, 523-531. McLellan, A.T., Hagan, T.A., Levine, M., Meyers, K., Gould, F., Bencivengo, M., Durell, J., & Jaffe, J. (1999). Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence*, 55, 91-103.

COMMENTARY ON LACK OF DISTINCTIVE FINDINGS

There are several striking findings from the studies reviewed in this chapter. First, most were conducted during the pre-professional stage of addiction counseling and compared non-degreed counselors in recovery with counselors not in recovery who had college or graduate degrees. Some observers have suggested that "the recovering person who has gotten himself well trained clinically has much more to offer than a therapist who is just recovering or well trained clinically,"[715] but studies are lacking that compare the effectiveness of recovering counselors and counselors without a history of addiction who have comparable levels of education and clinical training.

Second, these studies have focused on the counseling role with people in the earliest stages of recovery and have not included the role of recovery status in the effectiveness of long-term, non-clinical recovery support services.

Third, these studies have focused on counselors with widely varying lengths of recovery and have not evaluated the effects of length or framework of personal recovery on helping effectiveness.

The findings to-date of no major differential effects of recovery status on addiction counseling or support might mean several things. They might mean that there simply are no such effects. They might mean that such differences do exist, but these differences disappear over time due to an exchange of learning (a synthesis of experiential and professional learning) that takes place between recovering counselors and counselors who do not have a history of addiction. They might also, as suggested earlier, mean that there are differences, but these differences are suppressed via education, training, supervision, and the sustained professsionalization of the recovering counselor. The state of our knowledge at this moment supports the conclusion of the Annapolis Coalition on Behavioral Health Workforce Education:

> *There are multiple pathways to competence, which may include elements of personal experience, training and professional development. However, none of these pathways guarantees competence*.[716]

In addition, the competence of addiction professionals does not by itself guarantee successful client outcomes. No one system (or program) has the resources and reach to address the total span of alcohol and other drug problems within local communities and the contextual factors that exacerbate these problems and create obstacles to long-term recovery. P-BRSS constitute a bridge between professional systems of care and the resources of the larger community—resources that must be mobilized to increase the prevalence of recovery within communities across the country.

---

[715] Flores, P.J. (1988). *Group psychotherapy with addicted populations*. New York: Haworth Press.

[716] Hoge, M. A., Morris, J. A., Daniels, A. S., Huey, L. Y., Stuart, G. W., Adams, N., et al. (2005). Report of recommendations: The Annapolis coalition conference on behavioral health work force competencies. *Administration and Policy in Mental Health, 32*(5/6), 651-663, quotation from p. 653.

Chapter Seven

Recent Studies of Recovery Coaching and P-BRSS

Summary of Key Findings

- Two federal programs currently administered by the Center for Substance Abuse Treatment 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.

In spite of the rapid proliferation of P-BRSS specialist roles, few studies have examined the effects of these support roles on the long-term recovery outcomes of those receiving and those providing such services. In this chapter, we will briefly review what is known about the two major federal programs that have contributed to the spread of P-BRSS, as well as model state and urban peer-service initiatives. We will also look at studies that have evaluated various aspects of P-BRSS roles.

The Recovery Community Services Program (RCSP)

In 1998, the Center for Substance Abuse Treatment (CSAT) began the Recovery Community Support Program—an initiative that provided federal funds to recovery community organizations to conduct recovery-focused community education and advocacy by and on behalf of recovering individuals and their families. Grantees mobilized local communities of recovery culturally and politically, increased the involvement of recovery community members in key policy discussions, launched local anti-stigma campaigns, assessed the recovery support needs of local communities, and developed programs to address those needs. Between 1998 and 2002, RCSP grantees across the country pursued these functions with growing success and visibility. Through its grantees, the RCSP initiative contributed significantly to the rise of a "new recovery advocacy movement."[717]

[717] 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.

In 2002, a policy change shifted the focus of the RCSP. The program was re-titled the "Recovery Community Services Program" and shifted from the earlier focus on community education and policy advocacy to the development of non-clinical recovery support services, with a particular emphasis on peer-based recovery support services. This shift brought RCSP grantees in closer alignment with the treatment system and provided to individuals and families RCSP services that might enhance treatment and long-term recovery outcomes. The following table displays CSAT's description of the redesigned RCSP.

CSAT's Recovery Community Services Program (RCSP)[718]

RCSP Goals: Under the RCSP, CSAT provides funding and support to recovery community groups and facilitating organizations to develop and deliver innovative peer-to-peer recovery support services in community settings. These services are intended to achieve the following goals:

1. Help prevent relapse
2. Promote timely re-entry into treatment when relapse occurs
3. Promote sustained recovery and an enhanced quality of life for participants

RCSP Activities: The RCSP grants are funded to conduct the following activities:

- Assess consumer, family, and other stakeholder strengths and resources, as well as community-specific recovery support needs
- Develop and strengthen collaborative relationships with other area service providers
- Develop a plan for delivering peer-to-peer recovery support services
- Deliver the services
- Document and evaluate the service program, using demographic and qualitative methods

Funding Levels: In Federal Fiscal Year 1998, CSAT presented awards to 19 projects, in the amount of $3.6 million. In Federal Fiscal Year 2001, 21 projects received a total of $4.8 million. In Federal Fiscal Year 2003, ten awards were made for a total of $3.25 million. In Federal Fiscal Year 2004, eight projects received awards in the amount of $2.8 million. In Federal Fiscal Year 2006, seven awards were made, for a total of $2.4 million. Most recently, in Federal Fiscal Year 2007, eight awards were made, for a total of $2.8 million. In FY 2008, no new projects were funded, and the program's future is uncertain.

[718] *Recovery Community Services Program: Program overview.* Retrieved November 14, 2008 from http://rcsp.samhsa.gov/about/overview.htm.

Peer-based recovery support services provided by RCSP grantees include:

- peer-led recovery support groups and meetings;
- recovery coaching or mentoring;
- peer case management, information, and referral;
- recovery learning circles and other forms of recovery-related adult education;
- coaching or training in:
    - life skills,
    - health and wellness,
    - education and career planning
    - leadership skills development; and
- alcohol- and drug-free social and recreational activities.[719]

Process evaluations have been conducted of the RCSP program that report data on service volume and the experience and lessons learned from RCSP grantees,[720] but to-date no formal studies of the RCSP have been published in the field's scientific journals, nor have there been any independent, unpublished evaluations that included data on long-term recovery outcomes of service recipients within programs funded by the RCSP.[721] From the standpoint of science, the effects of the recovery support services provided by RCSP grantees on those served through this project are unknown.

The RCSP is evaluated primarily through benchmarks established by the Center for Substance Abuse Treatment under the Government Performance Results Act of 1993. RCSP grantees exceeded these benchmarks, with service recipients across all RCSP cites reporting an 85% abstinence rate, 62% rate of employment with no criminal involvement, and 61% living in recovery-conducive housing.[722]

THE ACCESS TO RECOVERY (ATR) PROGRAM

The Access to Recovery (ATR) program is a Presidential initiative begun in 2004, through which federal funds are allocated to expand the number of people receiving addiction treatment and non-clinical recovery support services in the United States. Two unique aspects of ATR include the expansion of service providers to include faith-based and other community service organizations that have not previously received public funding and a voucher

---

[719] *Recovery Community Services Program: About the RCSP program.* (2006). Retrieved November 14, 2008 from http://rcsp.samhsa.gov/about/index.htm.

[720] *Center for Substance Abuse Treatment Recovery Community Support Program: Grantee accomplishments and lessons learned.* (2001). Retrieved November 14, 2008 from http://rcsp.samhsa.gov/_pubs/lessons_learned_2001.pdf.

[721] Literature searches failed to reveal any RCSP studies in peer-reviewed journals, nor were any such studies identified by persons who have worked closely with the RCSP: Personal communications with Marsha Baker and Bonnie Veysey, November 2008.

[722] Recovery Community Services Program (2008) Face sheet prepared by Faces and Voices of Recovery.

program that enhances service consumer choice in selecting a service provider. The ATR program began with awards to 14 states and one tribal government in 2004, and ATR awards were granted in 2007 to 18 states, the District of Columbia, and five tribal organizations. To-date, approximately $300 million have been allocated to ATR services.

One purpose of the ATR program was to increase access to treatment and recovery support for special underserved populations, including pregnant women; women in the child welfare system; men, women, and youth returning to the community from jails and correctional facilities; men and women involved in drug courts due to methamphetamine dependence; and those living in rural areas with limited service resources. To-date, more than 170,000 people have been served through the ATR program, which is now administered by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA).[723]

Like the RCSP, there have been no studies of the ATR program published in peer-reviewed, scientific journals. However, ATR grantees do report service data through the SAMHSA Services Accountability Improvement System (SAIS). SAIS data answer at least some critical questions related to the ATR program. First, services provided through ATR have gone beyond traditional treatment services: 63% of ATR clients have received recovery support services, and a total of 48% of all ATR dollars have been used for recovery support services. Second, the goal of expanding the treatment and recovery support network is being achieved: 31% of ATR dollars have gone to faith-based organizations.

The long-term effects of ATR services are more difficult to determine. This question involves the extent to which these services facilitate the early interruption of addiction careers, enhance recovery initiation and stabilization, sustain recovery maintenance, and enhance quality of life in long-term recovery. Of these four dimensions, reports are available to answer only the second dimension, recovery initiation and stabilization. The SAIS data provided by ATR grantees document the following key findings:

- 71.4% of ATR clients were abstinent at discharge from service.
- At discharge, 22.3% of clients with housing problems at intake had resolved these problems.
- 29.3% of clients unemployed at intake had achieved employment by discharge.
- 59.5% of clients who were not connected to social support for recovery had achieved such connection by discharge.
- 84.7% of clients involved with the criminal justice system were no longer involved at discharge.[724]

The extent to which these gains were sustained following discharge is unknown.

---

[723] *SAMHSA Access to Recovery (ATR) grants: 2007 ATR factsheet.* (2007). Retrieved November 14, 2008 from http://atr.samhsa.gov/Factsheet07.aspx. *State ATR program descriptions.* (2007). Retrieved from http://atr.Samhsa.gov/stateprograms.aspx.

[724] *ATR Aggravated Data Profile*. (2007). Retrieved November 14, 2008 from http://atr.samhsa.gov/downloads/aggregate_march07.pdf.

Mangrum conducted one of the few evaluation reports of ATR.[725] This study of ATR services in Texas between 2004 and 2007 drew several important conclusions. First, ATR clients entered treatment with less severe substance-related problems than did non-ATR clients—a factor that may have contributed to the finding that ATR clients achieved better treatment completion rates and abstinence-at-discharge rates than non-ATR clients achieved. Another factor that may have influenced these positive outcomes is the fact that ATR clients tended to stay in treatment longer. The best intermediate recovery outcomes were achieved by clients who received support services directly linked to recovery initiation and stabilization: recovery coaching, recovery support groups, and relapse prevention training. Support services such as housing, transportation, and employment coaching were unsuccessful in the absence of addiction treatment. Again, the extent to which the gains achieved through participation in ATR services are sustained in the months and years following treatment is unknown.

STUDIES OF SERVICE ELEMENTS RELATED TO P-BRSS

The lack of studies of the major P-BRSS initiatives at the federal, state, and local levels makes it difficult to respond to questions related to the effectiveness of such services. There have, however, been studies of particular functions or elements within P-BRSS that can cast light on their potential value. Representatives of such studies include the following.

- Outreach: Project SAFE in Illinois successfully used outreach workers to engage hard-to-reach women with histories of addiction and child neglect.[726] Coviello, Zanis, Wesnoski, and Alterman[727] used an outreach intervention delivered by bachelor's-level case managers to successfully re-engage methadone clients who had relapsed following their discharge from treatment.[728]

---

[725] Mangrum, L. (2008). *Final Evaluation Report: Creating access to recovery through Drug Courts*. Texas Department of State Health Services, Mental Health and Substance Abuse Services Division. Austin, Texas: Gulf Coast Addiction Technology Transfer Center.

[726] White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best practices resource manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[727] Coviello, D.M., Zanis, D.A., Wesnoski, S.A., & Alterman, A.I. (2006). The effectiveness of outreach case management in re-enrolling discharged methadone patients. *Drug and Alcohol Dependence*, *85*, 56-65.

[728] Also see: Bradford, J.B. (2007). The promise of outreach for engaging and retaining out-of-care persons in HIV medical care. *AIDS Patient Care STDS*, Supplement 1, 21, S85-91. Fisk, D., Rakfeldt, J. & McCormack, E. (2006). Assertive outreach: An effective strategy for engaging homeless persons with substance use disorders into treatment. *American Journal of Alcohol and Drug Abuse*, 32(3), 479-86. Rahimlan, A. & Pach, A. (1999). Stories of AIDS outreach and case management: Context and activities. *Substance Use and Misuse*, 34(14), 1991-2014.

- Recovery Coaching: Klein, Cnaan, and Whitecraft[729] studied a peer support program for people with co-occurring psychiatric and substance use disorders. Those who received the services of a "friend's connector" (peer recovery coach) had dramatically fewer crises and hospitalizations, less alcohol and drug use, improved living circumstances, enhanced income, and enhanced health compared to those who did not receive recovery coaching. Ryan, Marsh, Testa, and Louderman (2006) found that the use of recovery coaches to help integrate addiction treatment and child welfare services for parents in substance-involved families enhanced access to treatment and resulted in increased rates of family reunification.
- Case Management: Case management has been found to improve addiction treatment engagement, treatment completion, and long-term recovery outcomes in adults and adolescents.[730]
- Supplemental Services: Increased ancillary medical and social services in addiction treatment have been consistently linked to enhanced recovery outcomes across treatment modalities.[731]
- Recovery Checkups: Recent studies have confirmed the utility of post-treatment recovery checkups (monitoring, support, re-intervention, re-linkage to treatment) on long-term recovery outcomes for adults[732] and

[729] Klein, A., Canaan, R., & Whitecraft, J. (1998). Significance of peer social support for dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, *8*, 529-551.

[730] Siegal, H.A., Rapp, R.C., Kelliher C.W., Fisher, J.H., Wagner, J.H., & Cole, P.A. (1995). The strengths perspective of case management: A promising inpatient substance abuse treatment enhancement. *Journal of Psychoactive Drugs*, *27*(1), 67-72. Siegal, H.A., Rapp, R.C., Li, L., Saha, P., & Kirk, K. (1997). The role of case management in retaining clients in substance abuse treatment: An exploratory Analysis. *Journal of Drug Issues*, *27*(4), 821-831.

[731] Berkman, N.D. & Wechsberg, W.M. (2007). Access to treatment-related and support services in methadone treatment. *Journal of Substance Abuse Treatment, 32*, 97-104. McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. F., & O'Brien, C. P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, *269*(15), 1953-1959. McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, *93*(10), 1489-1499.

[732] Cacciola, J. S., Camilleri, A. C., Carise, D., Rikoon, S. H., McKay, J. R., McLellan, A. T., et al. (2008). Extending residential care through telephone counseling: Initial results from the Betty Ford Center Focused Continuing Care protocol. *Addictive Behaviors, 33*, 1208-1216. McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*(11), 1594-1610. McKay, J.R., Lynch, K.G., Shepard, 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. 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.* Scott, C. K., Dennis, M. L., & Foss, M. A. (2005). Recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, *78*, 325-338.

adolescents.[733] The studies have not reported on the recovery status of those conducting the face-to-face or telephone recovery checkups, so the degree to which these effects would be sustained or even enhanced within a peer delivery model is unknown.

Positive studies of key service elements provided by recovery coaches suggest that P-BRSS is a potentially promising practice as an adjunct to addiction treatment. Any determination of the extent to which P-BRSS can elevate long-term recovery outcomes will require additional studies of such services. Suggestions for such future research are outlined in the next chapter.

[733] 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.

Chapter Eight

A P-BRSS Research Agenda

Summary of Key Points

- 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.

Toward a Recovery Research Agenda

The author has argued through a long series of publications that pathology- and intervention-focused research agendas within the addiction field must be substantively extended to encompass a recovery-focused research agenda.[734] Such an agenda would plot the long-term pathways, styles, and

[734] 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. White, W. (2007). In search of the neurobiology of addiction recovery: A brief commentary on science and stigma. Posted at: http://www.facesandvoicesofrecovery.org/pdf/White/White_neurobiology_2007.pdf. White, W.L. & Chaney, R.A. (2008). Intergenerational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know. Posted at

stages through which severe AOD problems are resolved within individuals, families, and communities and extract lessons that could guide the design of clinical treatment and non-clinical recovery support services.[735] It would also evaluate the role of peer-based recovery support services in long-term addiction recovery. In this chapter, we will explore some of the questions that should be addressed related to P-BRSS within this larger recovery research agenda.

COMMUNITIES OF RECOVERY AS ETHNO-CULTURAL COMMUNITIES

There are important parallels between communities of color and communities of recovery. Recovery research that involves investigation of recovering people, communities of recovery, and recovery community institutions should be informed by the historical role of research in communities of color. White and Sanders describe this role.[736]

> *People of color and communities of color have been wounded in a number of ways by culturally dominant research studies. They have been subjected to grossly unethical research practices (e.g., withholding medical treatment from 399 African American sharecroppers in the Tuskegee Syphilis Study). They have been stereotyped via reports characterizing the presence or absence of AOD problems in terms of racially dictated, biological vulnerability—from the "firewater" myths of racial vulnerability of Native Americans[737] to the myth of racial invulnerability of Asians.[738] They have been wounded by the assumption of universal applicability—the misapplication of research findings from studies in which no people of color were included. Communities of color have been injured by bad ("junk") science, such as the now-discredited, sensationalist literature on crack cocaine and "crack babies" that turned the criminal justice and child welfare systems into occupying institutions within poor communities of color.[739] They have been shamed by research designs and interpretations that dramatized the problems within*

---

www.facesandvoicesofrecovery.org. White, W. & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, *19*(2), 20-25.

[735] Laudet, A.B. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusion and future directions for service development and research. *Substance Use and Misuse*, 43(12), 2001-2020.

[736] White, W. & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[737] Leland, J. (1976). *Firewater myths: North American Indian drinking and alcohol addiction.* New Brunswick, New Jersey: Rutgers Center of Alcohol Studies. Westermeyer, J. (1974). "The drunken Indian:" Myths and realities. *Psychiatric Annals, 4*(11), 29-36.

[738] O'Hare, T. & Tran, T.V. (1998). Substance abuse among Southeast Asians in the U.S.: Implications for practice and research. *Social Work in Health Care, 26*(3), 69-80.

[739] Frank, D.A., Augustyn, M., Knight, W.G., Pell, T., & Zuckerman, B. (2001). Growth development and behavior in early childhood following prenatal cocaine exposure: A systematic review. *Journal of the American Medical Association, 285*, 1613-1625.

communities of color while ignoring their strengths and resiliencies.[740] *Observers from within ethnic communities have also been very critical of how communities of color have been used as a valuable resource to enrich individual careers and institutions in exploitive processes that returned nothing to communities of color.*[741] *…Given this history, scientists and scientific institutions bear a continued burden of proof regarding their safety, relevance, and benefit to communities of color. Achieving such credibility will require, at a minimum, the inclusion of community of color leaders and members in the design, conduct, interpretation, and dissemination of research and evaluation studies.*[742]

The conduct of research in communities of recovery requires similar levels of sensitivity toward the potential for harm and strategies for achieving credibility within those communities.

More than ever, ethnocultural communities demand that research occur in their communities under their direction and control. Researchers should be prepared to collaborate with communities, share results that have practical value, and accept the conditions imposed by the community in gaining access to information and respondents.[743]

As we proceed into this chapter, we will try to identify some of the most critical questions whose answers will shape the future of peer recovery support services. These lists are by no means comprehensive, but they do convey some of the basic questions for which we currently lack answers.

---

[740] Coyhis, D. & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance, resilience and recovery*. Colorado Springs, CO: White Bison, Inc.

[741] Casas, J.M. (1992). A culturally sensitive model for evaluating alcohol and other drug abuse prevention programs: A Hispanic perspective. In M.A. Orlandi (Ed.), *Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities* (pp. 75-116). Rockville, MD: Office of Substance Abuse Prevention.

[742] Hermes, M. (1998). Research methods as a situated response: Towards a First Nations' methodology. *Qualitative Studies in Education, 11*(1), 155-168.

[743] Trimble, J.E. (2008). Commentary: No itinerant researchers tolerated: Principled and ethical perspectives and research with North American Indian communities. *ETHOS*, *36*(3), 380-383.

RESEARCH ON RECOVERY MUTUAL-AID GROUPS

There is an extensive list of unanswered research questions related to addiction recovery mutual-aid groups. The following are among the most important to the future of P-BRSS linked to addiction treatment.

- Can the findings of research on AA be applied to other 12-Step programs and to explicitly religious and secular recovery support groups?
- How do affiliation and long-term recovery rates differ across and within mutual-aid groups representing religious, spiritual, and secular frameworks of recovery?
- What mechanisms of change are common across existing addiction recovery mutual-aid groups, and which are distinctive to particular frameworks of recovery?
- Is there scientific evidence of inadvertent harm resulting from participation in a recovery support group? If so, how might harm be minimized? Are certain types of groups contraindicated for particular types of individuals/families?
- What is the influence of having multiple choices of recovery support fellowships on rates of affiliation, participation, and long-term recovery?
- What interventions increase initial affiliation rates, reduce early dropout rates, and enhance long-term participation in recovery mutual-aid groups?
- What happens to those people who drop out of recovery support group involvement after varying lengths of participation? Do these effects vary across populations and recovery support groups?
- Does concurrent participation in more than one recovery support group generate additive or antagonistic effects?
- Are the effects of combining professional counseling, peer-based recovery coaching, and participation in recovery mutual-aid fellowships greater than the effects of participating in only one of these respective elements?
- Do the effects of participation in recovery mutual-aid groups vary for clients involved in different treatment modalities/levels of care?
- Are there particular populations for whom recovery mutual-aid group involvement might constitute an alternative to professionally directed treatment services?
- How do levels and styles of participation in recovery mutual-aid groups differ across ethnic and cultural groups? Are additive or synergistic effects achieved when recovery mutual-aid participation is combined with participation in religious/cultural revitalization movements and/or traditional healing practices?
- Are there special support groups or peer support mechanisms that enhance recovery rates for people with addiction histories re-entering communities from jail or prison?

Participation in Other Recovery Community Institutions

Non-clinical recovery support services have generally been defined in terms of recovery support groups such as AA, but as we have outlined in this monograph, recovery support services are becoming much more diverse and are being combined in unique ways. Recovery homes in the Oxford House network currently constitute the most often-studied recovery community institution other than AA/NA. There is a need for parallel research on recovery community organizations, recovery-oriented media and leisure activities, volunteer programs, recovery social clubs, recovery industries, recovery schools, and recovery ministries/churches. These studies should address such questions as:

- What are the effects of participation in these respective institutions on long-term recovery outcomes for individuals and family members?
- How does involvement in recovery support institutions influence key dimensions of recovery: abstinence rates, elevations in global health and functioning, community re-integration, and citizenship?
- Does participation in recovery community institutions reduce the risk of injury to others, e.g., threats to the safety of family members, threats to public safety, criminality, or the social burden related to addiction-related costs?
- Do the growth of recovery community institutions and the more public visibility and growth of communities of recovery change public and policy-maker attitudes and create a more recovery-friendly public policy environment?
- Are post-treatment recovery outcomes enhanced by adding one or more of these recovery support ingredients to professional treatment?
- Are there particular combinations of service/support elements that generate dramatically enhanced effects on recovery outcomes (the psychosocial equivalent of the AIDS cocktail)?

Recovery Representation in Professional Treatment

The bulk of professional literature on people in recovery working in addiction treatment dates from the 1970s and early 1980s—the "paraprofessional" and early professionalization stages of addiction counseling. The call for "recovery-oriented systems of care" and "authentic recovery representation" within such systems is once again raising questions about the roles recovering people fill within the addiction treatment field and its local organizations. Here are a few of the most basic questions that should be answered.

- What is the level of individual/family recovery representation at the board, executive, management, direct service, and volunteer levels of organizations whose mission includes the planning, funding, delivery, or evaluation of addiction treatment and recovery support services?

- To what extent do those recovery representatives reflect the diversity of American communities of recovery in terms of gender, age, ethnicity, sexual orientation, and recovery pathways?
- Given the increased homogenization of pre-service education and training and professional socialization, are there significant differences between the effectiveness of recovering addiction counselors and that of counselors without a history of addiction (as measured by recovery outcomes of assigned clients)?
- How does the risk of relapse (and other areas of work-related impairment) for recovering addiction counselors and P-BRSS specialists compare to the risk of other types of occupational impairment for counselors and P-BRSS specialists who do not have a history of addiction?
- Is the risk of relapse for the recovering counselor working in addiction treatment different from addiction counselors' risk of relapse for other chronic health conditions (e.g., cancer, asthma, diabetes, heart disease)?
- How does the recovery status of recovering people with post-baccalaureate training in psychiatry, psychology, social work, and psychiatric nursing effect service outcomes of clients treated by these individuals?

PERSON-SPECIFIC FACTORS AFFECTING RECOVERY OUTCOMES

Studies that have attempted to match particular treatments to the demographic and clinical characteristics of clients entering addiction treatment have not generated support for the many matching hypotheses that have been proposed.[744] But the lack of matching effects in one arena (professionally directed treatment) does not mean that significant matching effects might not exist in another arena (peer-based recovery support services). Key research questions related to such person-specific factors include the following:

- What client characteristics are linked to the most successful P-BRSS-related recovery outcomes?
- Are there populations for whom P-BRSS are contraindicated?
- Are there matching factors other than recovery status (e.g., age, gender, ethnicity, sexual orientation, primary drug choice, recovery pathway) that influence outcomes?
- How do the effects of P-BRSS differ, if at all, across the boundaries of gender, developmental age, race/ethnicity, sexual orientation, religiosity, primary drug, problem severity, and problem complexity?

[744] Project MATCH Research Group. (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29; For a review of the lack of significant findings from treatment matching studies, see Imel, Z.E. & Wampold, B.E. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. Psychology of Addictive Behaviors, 22(4), 533-543.

- Do P-BRSS generate pro-recovery effects in people who have refused to go to professionally directed addiction treatment?
- What factors (e.g., problem severity/complexity, recovery capital, frequency/intensity of cravings, and threat to self/others) might determine the level of intensity of P-BRSS that should be provided?
- What are the attitudes of individuals and families toward long-term monitoring and support? What percentage of individuals/families stay involved in the monitoring process across key temporal benchmarks (first 90 days, first year, three years, and five years)?

P-BRSS and Stages of Recovery

If we assume that there are developmental stages of recovery that vary across clinical populations and individuals, and that service and support needs evolve through these stages, then the development of stage-specific recovery support services becomes a critical component of long-term recovery management. Here are some key questions that be answered if we are to achieve that goal.

- Are particular types of P-BRSS more effective at particular stages of recovery or within particular zones of recovery?
- What are the effects of pre-treatment P-BRSS on treatment seeking, treatment engagement, and long-term recovery outcomes?
- Would in-treatment P-BRSS enhance treatment completion rates?
- What differences in linkage rates exist between peer-based and professional-based linkage to recovery support groups?
- Do post-treatment P-BRSS lower post-treatment relapse and re-admission rates?
- What effects do P-BRSS exert on enhanced quality of life in long-term recovery?
- Are there P-BRSS that lower the risk of late-stage relapse in recovery (e.g., relapse after ten or more years of stable sobriety)?

P-BRSS Service Roles

As noted in earlier chapters, new recovery support roles are being created and widely replicated within recovery community organizations; addiction treatment institutions; and allied mental health, child welfare, public health, and criminal justice agencies. Questions that are arising related to these roles include the following:

- What characteristics of P-BRSS specialists are linked to enhanced recovery outcomes?
- What is the current profile of recovering people working in non-clinical recovery support roles?

- Do recovery outcomes differ by the duration or quality of recovery of those providing professional treatment or P-BRSS?
- How can stability and quality of recovery be measured in the screening of those wishing to provide P-BRSS?.
- Do recovery outcomes differ by recovery pathway (religious, spiritual, secular) of the professional or P-BRSS helper?
- Are there differences in recovery outcomes when P-BRSS are delivered in voluntary versus paid roles?
- Do family members in recovery bring knowledge, experiences, and skills that uniquely qualify them for the delivery of P-BRSS? For example, would a randomized, controlled trial of P-BRSS by AA members, Al-Anon members, and persons not in personal or family recovery generate different recovery outcomes among those with whom they work?
- What are the most frequent ethical dilemmas encountered in the delivery of P-BRSS? How do P-BRSS specialists respond to ethical dilemmas that arise during service delivery?

SERVICE INGREDIENTS AND RECOVERY OUTCOMES

The spectrum of services offered within the umbrella of P-BRSS is extensive and ever-growing. Basic questions related to these service ingredients include the following:

- What are the precise mechanisms through which P-BRSS exert an influence on recovery outcomes?
- What are the most potent ingredients within P-BRSS?
- How do the frequency and sequencing of P-BRSS affect recovery outcomes?
- How does the duration of P-BRSS affect long-term recovery outcomes? (Research confirms that recovery does not become durable—the point at which the risk of future lifetime relapse drops below 15%—until five years of continuous recovery.[745] Should P-BRSS, at least in the form of annual recovery check-ups, be extended for five years?)
- How long can people be voluntarily engaged in post-treatment monitoring and support?
- What specialized P-BRSS protocols are indicated for key populations: for example, persons with extensive history of post-treatment relapse, persons consuming inordinate levels of system resources, persons living in zip codes indicating high AOD saturation?

---

[745] For a review, see 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.

- Can P-BRSS reduce future health care costs, including reducing or eliminating the costs of future episodes of acute-care addiction treatment?
- Do P-BRSS reduce threats to public safety when they are provided to groups that pose such threats, such as multiple DUI offenders?
- What differences in effects, if any, exist among different P-BRSS delivery media (face-to-face, telephone-based, Internet-based services)?
- What are the respective contributions to recovery of peer-based intrapersonal, interpersonal, and environmental interventions?
- What benefits, if any, are added when peer helpers are included within professional service teams (for example, effects on performance of professional staff, additive effects of peer/professional collaboration)?

Interaction Between P-BRSS and Professional Treatment

The ideal relationship between P-BRSS and professionally directed addiction treatment has yet to be scientifically validated. Questions concerning this relationship include the following:

- Under what circumstances might P-BRSS stand as an alternative rather than an adjunct to professionally directed addiction treatment?
- Are there additive or synergistic effects when P-BRSS and professionally directed addiction treatment are combined?
- Do the effects of P-BRSS on recovery outcomes differ when they are combined with different treatment modalities and levels of care?
- How would the infusion of P-BRSS into methadone maintenance treatment and other medication-assisted treatment affect long-term recovery outcomes?
- Can pre-treatment outreach and engagement expand the number of people entering addiction treatment for the first time?
- Does the source through which a person hears about or accesses P-BRSS influence recovery outcomes?
- Does the delivery of P-BRSS in tandem with addiction treatment increase treatment dose, treatment completion rates, rate of linkage to recovery support groups, and participation in post-treatment continuing care services?
- Does the delivery of P-BRSS following addiction treatment lower post-treatment relapse rates and speed recovery re-stabilization for those who do lapse/relapse?

P-BRSS AND FAMILY/COMMUNITY RECOVERY OUTCOMES

Our need to study the potential of P-BRSS transcends questions about individual recovery outcomes.[746]

> *Research on the effects of addiction recovery on the family challenges the expectation that families rapidly regain health following recovery initiation.[747] Family structure, roles, relationships, rules, and rituals are dramatically altered through the process of addiction and must be abandoned and reformed in recovery.[748] This stressful family re-adjustment process has been depicted as the "trauma of recovery."[749] The chaotic family environment of the addiction years continues into the early years of recovery. Without support, this adjustment threatens both the marital relationship and family stability*.[750]

Such findings suggest the need for family-focused P-BRSS, particularly family-focused recovery checkups, recovery education, and recovery support, that extends at least through the early years of recovery initiation and stabilization. Due to the intrapersonal orientation of current models of addiction treatment, most P-BRSS models tend to focus on services to individuals. There are, however, calls for the development of peer service models aimed at increasing family and community recovery capital.[751] Critical research questions related to such strategies include the following:

- What effects do family-focused P-BRSS exert on key recovery measures (for example, reducing the number, duration, and intensity of relapse episodes; enhancing long-term recovery outcomes, including increases in global health)?
- What effects do family-focused P-BRSS exert on key measures of family health and functioning (family roles, family rules, family rituals, subsystem relationships, and boundary transactions with extended kinship and community support networks)?

---

[746] Quote below excerpted from White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

[747] Brown, S. & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

[748] White, W. & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

[749] Brown, S. & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford. See also Schmid, J. & Brown, S. (2008). Beyond "happily ever after": Family recovery from alcohol problems. *Alcoholism Treatment Quarterly*, 26(1/2), 31-58.

[750] Brown, S. & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

[751] White, W. & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment,* 36, 146-58 .

- What influences, if any, do P-BRSS exert on the intergenerational transmission of AOD problems? Do P-BRSS services targeting one family member lower the risk that other family members will develop substance use disorders, or enhance the prognosis for recovery among other family members who develop such disorders?
- Does the delivery of family-focused P-BRSS reduce indicators of family strain and disorganization (health challenges of individual family members, divorce rates, reports of child abuse/neglect, placement of children outside the home, or truancy rates of children)?
- Does the development of formal P-BRSS in a community elevate or weaken the service ethic within local communities of recovery?
- Is there a recovery "tipping point" at which saturating P-BRSS in a certain community area reduces the prevalence of addiction in that area?

Research studies are needed on the effects of family-focused P-BRSS models compared to individual-focused P-BRSS and the absence of P-BRSS.

Organizational Contexts and P-BRSS Outcomes

P-BRSS are being provided through a variety of organizational contexts. Key research questions related to the influence of these contexts include the following:

- Are there differences in recovery outcomes across different P-BRSS delivery sites, e.g., addiction treatment programs versus recovery community organizations?
- Do recovery outcomes differ across for-profit and not-for-profit P-BRSS providers?
- What are the potentials and pitfalls of forging relationships between professional treatment organizations and indigenous recovery community organizations?
- What are the most viable financing models for P-BRSS?
- What are the possible cost offsets that can be achieved through P-BRSS (including future addiction treatment and health care costs)?
- How can government actions help or harm the development of indigenous recovery community organizations?
- Do governmental interventions that reduce discrimination and improve employment and housing opportunities influence recovery outcomes?
- What are the effects of accepting particular types of funding on the character of indigenous recovery community or faith-based organizations?

CONCERNS ABOUT P-BRSS

We also need research on the processes of implementing P-BRSS within different service systems. Arguments against P-BRSS shared with the author during training and consultation events are listed in the table that begins below, along with brief commentary related to each.

Table 11: Concerns about P-BRSS Raised by Addiction Professionals, Treatment Administrators, and Members of the Recovery Community

Concern/Contention about P-BRSS	Brief Commentary
We're already "recovery-oriented." Why do we need to add P-BRSS?	The current system of addiction treatment in the United States can achieve acute biopsychosocial stabilization more safely and effectively than it has ever been achieved in history. Rigorous reviews of treatment system performance data[752] suggest that most clients with high problem severity/complexity and low recovery capital are not extending these brief sobriety experiments into sustainable recovery. P-BRSS are an effort to, in part, enhance and protect the transition from recovery initiation to stable recovery maintenance and enhanced quality of life in the community. Whether P-BRSS can increase the likelihood of a successful transition must be definitively answered through methodologically rigorous studies.
The popularity of P-BRSS is the first step toward the de-professionalization and de-funding of addiction treatment.	P-BRSS are an alternative to professionally delivered addiction treatment services only for those individuals with low-to-moderate problem severity and very high recovery capital. Beyond that, these services are best viewed as adjuncts or enhancements to professional services. Given the tenuous, probationary status of addiction treatment as a cultural institution, it will be important to guard against any political effort that views P-BRSS as a cheap replacement for professionally directed treatment. At the same time, addiction treatment leaders must avoid overselling the likelihood that brief episodes of professional treatment will generate sustainable recovery for most clients when such treatment is not combined with sustained post-treatment monitoring and support.

[752] White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

Concern/Contention about P-BRSS	Brief Commentary
No one will pay for P-BRSS. Funding for these services must come out of existing dollars allocated for treatment services. More P-BRSS means less treatment.	P-BRSS are one part of the shift from viewing addiction as an acute problem to viewing it as one that can be managed like other chronic conditions. That means the provision of a longer continuum of pre-treatment, in-treatment, and post-treatment recovery support services to bolster and sustain the effects of professional treatment, reducing health care and other costs because of enhanced recovery rates and lowering treatment re-admission rates. Because of this, federal and state governments are funding P-BRSS or organizations that deliver them, and third-party payors are reimbursing for P-BRSS, either through enhanced case rates that include P-BRSS or through capitated contracts specifically for P-BRSS, and through self-pay to the organizations delivering these services. Under conditions of fixed or declining resources, increasing funding for P-BRSS might result in decreased funding for professional treatment services. However, it might also result in the allocation of more funding to professional treatment because of better recovery outcomes. The policy question concerns the combination of services that reflects the best stewardship of resources in terms of personal, family, and community benefits and the quantity and quality of recovery outcomes.
If I am no longer the expert (as a professional not in recovery), why did I spend all that time and money going to school? What does this P-BRSS trend bode for my professional future? I sometimes feel like my expertise is not respected by those advocating P-BRSS.	A premise of P-BRSS is that traditional clinical services are critical for many of the more than 20 million Americans who have yet to find recovery, but that for many of these people, professional treatment alone will not enable them to achieve and sustain long-term recovery. The effects of professional services may be dramatically enhanced when they are combined with P-BRSS. Studies of long-term recovery may also reveal that professionals have significant contributions to make during the later stages of recovery, when emotional and family distress peak and when many people in recovery consciously reshape their character and significant relationships.[753]

[753] This potential benefit is evident from the increase in AA members who received some form of treatment or counseling after coming to AA—up from 40% in 1980 to 65% in 2004. In the latest survey, 84% of AA members reported that the professional help they received had played an important role in their recovery. Maxwell, M.A. (1984). *The Alcoholics Anonymous experience*. New York: McGraw-Hill Book Company. Alcoholics Anonymous (2005). *Alcoholics Anonymous 2004 membership survey*. New York: A.A. World Services.

Concern/Contention about P-BRSS	Brief Commentary
P-BRSS are the equivalent of practicing medicine without a license. We professionalized the role of the addiction counselor in the first place to avoid just this problem.	Clear role delineation, sound training, and rigorous and sustained supervision will be needed to ensure that P-BRSS specialists practice only within the boundaries of their education, training, and experience. It is critical that P-BRSS specialists not cross the boundary separating non-clinical and clinical services.
People in recovery are not stable enough to withstand the rigor of work in addiction treatment; they will create problems due to absenteeism, poor performance, relapse, and high position turnover.	"Indigenous workers are no panacea, but properly trained, and properly used, they can be an important new force…"[754]
P-BRSS will result in harm to people who really need help, because these peers or parapofessionals' involvement will lower competency standards and increase the number of breaches in ethical conduct. Hiring people in recovery will hurt the professional reputation of our organization.	There is no evidence that P-BRSS cause more harm than professional treatment. Everyone seeking to help individuals and families recover should be committed to minimizing risk of harm. For P-BRSS, that means defining the core knowledge and skills of P-BRSS specialists, creating ethical guidelines specific to P-BRSS roles, and providing training and supervision that ensures competency and adherence to ethical standards.
P-BRSS specialists are just "paid sponsors." Why are we paying someone to do what is freely available from local recovery support groups? Won't bringing money into this weaken the service ethic within the recovery community?	A sponsor is different from a recovery coach, and their roles must be delineated clearly by every organization providing P-BRSS.[755] The recovery coach can be paid or work on a volunteer basis, depending on the organization with which he or she is involved. P-BRSS should not replace support provided by sponsors or other indigenous community support resources. If they do, it would cause great harm to local recovery communities and constitute a great iatrogenic effect of P-BRSS.

The sources of resistance to P-BRSS and the most effective strategies for implementing P-BRSS deserve detailed study.

[754] Reiff, R. & Reissman, F. (1970). The indigenous nonprofessional. *Community Mental Health Journal*. Monograph No. 1.

[755] White, W. (2006c). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity.* Philadelphia, PA: Philadelphia Department of Behavioral Health.

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 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.

But 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 specifically those in recovery bring to the helping process. David Deitch and Daniel Casriel's view of this contribution is as relevant today as it was in 1967.

> *There is no magic attached to any label, and we would do well to avoid creating a new vogue in the hopes of an instant solution to a complex problem. There is, instead, the necessity that helpers relate not primarily through techniques, but through humanness. And, indeed, ex-addicts have frequently indicated a marked ability to do so. But this is not because they once experienced drug addiction. It is, rather, because they completed their own recovery experiences, and emerged as men and women committed to this demanding way of life*.[756]

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. But 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

---

[756] Deitch, D. & Casriel, D. (1967). The role of the ex-addict in the treatment of addiction. *Federal Probation*, 31, 45-47.

"unencumbered by 'professionalism' and entanglement in bureaucracy" and were free to "interact with patients in a less formal, more spontaneous fashion than professionals."[757] 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.[758]

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 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.

P-BRSS specialists offer a rich source of experience-based guidance on individual/family recovery management, but they may be prone to forcing the recovery of those with whom they work into the conceptual framework of their own unique recovery experience. The grassroots, generalist, and "whatever it takes" qualities of the P-BRSS role are sources of its effectiveness, but the resulting problems (e.g., role ambiguity, role conflict, lack of career mobility) can trigger the move toward role specialization, professionalization, and the commodification and commercialization of peer support.

The P-BRSS values of empowerment, autonomy, self-determination, and choice offer a distinct alternative to the role of coercion that still holds sway in many segments of specialty-sector addiction treatment. However, these same values may limit the utility of this model for individuals who pose significant threats to themselves, their families, and the community. P-BRSS models with strong advocacy and community development components offer distinct advantages over models that focus exclusively on intrapersonal change, but these very components can constitute a diversion from the immediate needs of individuals/families and can bring the agency involved in P-BRSS into conflict with powerful community institutions.

Professional service models experience a similar duality. The role specialization in professional models of care can bring unparalleled levels of expertise, but have also contributed to the service silos and fragmentation of care that have ill-served individuals and families with multiple problems. Professional

---

[757] Suchotliff, L. & Seligman, E. (1974). The myth of the ex-addict staff. *Drug Forum*, 4(1), 47-51.

[758] White, W. (2002b). *Toward a vision of peer-driven and peer-led recovery support services*. Presented at Recovery Community Support Program Conference, July 23, 2002, Washington D.C.

codes of ethics have enhanced the safety of service consumers, reduced professional liability, and ensured a degree of detachment and objectivity, but they have also contributed to rule-based decision-making that can convey fear of involvement, aloofness, snobbishness, disinterest, or contempt—particularly toward individuals hypersensitive to such slights.

The intrapersonal focus of professional service models has great individual healing power, but has often neglected families and kinship networks and the larger social pathologies in which personal problems are often embedded. The professional emphasis on accurate differential diagnosis and problem-focused service planning has aided many people, but this emphasis can lead to a preoccupation with pathology at the expense of recovery. Also, the theoretical models that help guide clinical intervention for the professional can be as blinding and biasing as the unique recovery experience of the P-BRSS specialist.

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."[759]

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.[760] P-BRSS specialists can help divert excessive attention from "funding streams," "product lines," and "bottom lines" and refocus attention toward long-term recovery pathways and processes for individuals and families.[761]

This must be done in a way that avoids the "us and them" polarizations between peer and professional models. The issue is not, "Who is more valuable: a doctor or a friend?" The issue is what individuals and families need at a particular moment in time. What people seeking recovery do not need are friends playing doctor or doctors abandoning their roles to become friends. It is not a question of one or the other. We need a community in which both are available as needed, and in which professional and peer-based services are supported and integrated into a seamless system of long-term recovery support.[762]

---

[759] McGovern, T. (1992). Alcoholism and drug abuse counseling: A personal reflection. *The Counselor*, *10*(3), 38-46.

[760] Gusfield's (1982) following observation seems apt here: "problem-solving occupations are sources of their own expansion. In serving others, the welfare state serves itself." p. 17. Gusfield, J. (1982). Deviance in the welfare state: The alcoholism profession and the entitlements of stigma. *Research in Social Problems and Public Policy, 2*, 1-20.

[761] Jenson, J. (2001). The recovering counselor as wounded healer. *Counselor Magazine*, *2*, 21-25.

[762] Kurtz, E. (1999). Commentary in "lay treatment" In. *The Collected Ernie Kurtz*, Wheeling, WV: The Bishop of Books, p. 83-90.

> *Most studies of ex-users and professionals imply a juxtaposition between them. There are few studies of how the two groups interact when they work together…. The actual realities of how ex-users and professionals interact, and who learns what from whom and under what circumstances, represent an important subject for needed research*.[763]

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. The long-term goal is the establishment of recovery support relationships that are non-hierarchical, non-commercialized, and enduring in recovery-friendly communities. We must not lose our recovery community development perspective as we venture into this peer-service arena.

The historical question "Who is most qualified to treat the alcoholic" is ill-framed because it assumes a homogeneity within the label "alcoholic" and within the boundaries of particular helping roles or categories of helpers. In terms of recovery status, the question is not whether professional and peer helpers with or without a history of addiction recovery are most effective, but which helper is most effective with which person or family at a particular point in time. The latter question suggests that different categories of helpers and different individuals may be of benefit to different individuals, and to the same person at different stages of the recovery process.

> *There are so many kinds of alcoholics and so many different kinds of alcoholism that perhaps no one person can qualify to treat all alcoholics, and a therapist eminently qualified to treat one type mail fail completely with another* (p. 121).[764]

Until we have a cartography that includes recovery pathways and stages for different subpopulations with different levels of AOD problem severity, matching helpers and helpees is likely to show as few effects as studies attempting to match particular treatments to particular clients.

Recovery stages might be broadly conceived in terms of: 1) a sudden or unfolding opportunity for change, 2) a commitment to recovery experimentation, 3) recovery initiation and stabilization, 4) recovery consolidation and maintenance, and 5) enhanced quality and meaning of life in long-term recovery. I suspect we will find P-BRSS services most critical in stage 1 (via outreach and engagement), stage 2 (via charismatic encouragement and role modeling), and

---

[763] Winick, C. (1990). The counselor in drug user treatment. *International Journal of the Addictions*, *25*(12a), 1479-1502, quote from page 1497.

[764] Block, M. (1964). Who is qualified to treat the alcoholic? Comment on the Krystal-Moore discussion. *Quarterly Journal of Studies on Alcohol. 25*, 121-124.

stage 4 (construction of a recovery-based identity, social network, and lifestyle). Traditional professionals may be most effective in stage 3 (facilitation of medical/psychological crisis management and stabilization) and stage 5 (providing psychotherapeutic support to resolve serious characterological defects and to enhance the quality of intimate and family relationships). In the end, we may well end up at the position Mitchell and Graham advocated in 1973: "A combination of 'square' or professional with ex-addict or paraprofessional is the logical answer to an improved service,"[765] but none of us working in 1973 could have envisioned the ways in which these talents could be combined and sequenced to support long-term recovery. Thirty-five years later, we are just beginning to develop such a vision.

A Preview

This monograph has left unanswered an array of questions related to how P-BRSS can be best implemented. Having set the historical, theoretical, and scientific foundation of peer recovery support services, the next monograph in this series will present a collection of papers on how such services are being implemented at the grassroots level. Announcement of the release of this monograph will be made on the web site of the Great Lakes Addiction Technology Transfer Center: www.attcnetwork.org/greatlakes.

[765] Mitchell, C.D. & Graham, T.C. (1973). The paraprofessional counselor in the treatment of narcotic addiction. *Proceedings—5th National Conference on Methadone Treatment*, *5*, 2e2-b55, quotation from page 254.

Appendix

Table 12: Changing Recovery Representation in the Addiction Treatment Workforce

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1960s/ early 1970s	Treatment Histories: White, 1998;[766] Winick, 1991 [767]	Staff roles	Therapeutic Communities	Nearly 100%		
1969	Bullington, et al.[768]	Streetworkers	Boyle Heights Narcotic Project	100%		
1973	Hoffman & Miner[769]	Alcoholism Counselor Trainees	Alcoholism unit of state hospital	100%		
1973	Reinstein[770]	Drug Counselors	Drug abuse program in VA Hospital	100%		
1973	Kozel & Brown[771]	Counselors at an addiction treatment unit	Narcotics Treatment Administration	58%		

[766] White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

[767] Winick, C. (1990). The counselor in drug user treatment. *International Journal of the Addictions*, *25*(12a), 1479-502.

[768] Bullington, B., Munns, J., & Geis, G. (1969). Purchase of conformity, ex-narcotic addicts among the bourgeoisie. *Social Problems, 16*(4), 456-63.

[769] Hoffman, H. & Miner, B.B. (1973). Personality of alcoholics who became counselors. *Psychological Reports*, *33*, 878.

[770] Reinstein, M.L. (1973). The role of drug counselors in a hospital drug-cure program. *Hospital and Community Psychiatry*, *24*(12), 839-841.

[771] Kozel, N.J. & Brown, B.S. (1973). The counselor role as seen by ex-addict counselors, nonaddict counselors and significant others. *Journal of Consulting and Clinical Psychology*, *41*, 315.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1974	Snowden & Cotler[772]	Ex-addict counselors	Methadone treatment program	100%		
1974	Brown, et al.[773]	Counselors	Narcotics Addiction Treatment Administration	68%		
1974	Wehmer et al.[774]	Paraprofessional alcoholism counselor trainees	Alcoholism treatment program	46%	38%	
1975	Cooke, et al.[775]	47 counselor trainees	Detroit Harbor Light Alcoholism Therapist Training Program	28%		
1975	Brown & Thompson[776]	Counselors	Narcotics Treatment Administration	51%		
1976	Rosenberg et al.[777]	Evaluation of training of 16 alcoholism counselors	Division of Alcoholism, Boston City Hospital	38%		

[772] Snowden, L. & Cotler, S. (1974). The effectiveness of paraprofessional ex-addict counselors in a methadone treatment program. *Psychotherapy: Theory, Research and Practice*, *11*(4), 331-338.

[773] Brown, B.S., Jansen, D.R., & Bass, U.F. (1974). Staff attitudes and conflict regarding the use of methadone in the treatment of heroin addiction. *American Journal of Psychiatry*, *131*(2), 215-219.

[774] Wehmer, G., Cooke, G., & Gruber, J. (1974). Evaluation of the effects of training of paraprofessionals in the treatment of alcoholism: A pilot study. *British Journal of Addiction to Alcohol and Other Drugs*, *69*(1), 25-32.

[775] Cook, G., Wehmer, G., & Gruber, J. (1975). Training paraprofessionals in the treatment of alcoholism: Effects on knowledge, attitudes and therapeutic techniques. *Journal of Studies on Alcohol*, *36*, 938-948.

[776] Brown, B. S. & Thompson, R. F. (1975). The effectiveness of formerly addicted and nonaddicted counselors on client functioning. *Drug Forum*, *5*(2), 123-129.

[777] Rosenberg, C., Gerrein, J, Manohar, V., & Liftik, J. (1976). Evaluation of training of alcoholism counselors. *Journal of Studies on Alcohol, 37*, 1236-1246.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1978	Talbott & Gillen[778]	Alcoholism counselors	Inpatient treatment program	100%		
1978	Longwell et al.[779]	Counselors	MMT	39%		
1978	Argerio & Manohar[780]	Counselors	Traffic safety project	57%		
1979	Berger-Gross et al.[781]	Paraprofessionals	State hospital alcoholism unit and detox center	85%		
1980	NDATUS, 1982[782]	National Survey of Treatment Units	Public and private programs	81%		
1980	Connett[783]	Counselors	Methadone treatment	44%		
1980	Winick[784]	Staff	NY Therapeutic Communities	54%		

[778] Talbott, J.A. & Gillen, C. (1978). Differences between nonprofessional recovering alcoholic counselors treating Bowery Alcoholics: A study of therapist variables. *Psychiatric Quarterly*, *50*(4), 333-342.

[779] Longwell, B., Miller, J., & Nichols, A.W. (1978). Counselor effectiveness in a methadone maintenance program. *The International Journal of the Addictions*, *13*(2), 307-315.

[780] Argeriou, M. & Monohar, V. (1978). Relative effectiveness of non-alcoholics and recovered alcoholics as counselors. *Journal of Studies on Alcohol, 39*, 793-799.

[781] Berger-Gross, V. & Lisman, S. (1979). Attitudes of paraprofessionals toward alcoholism: Setting effects. *Journal of Study on Alcohol, 40*, 514-517.

[782] National Drug and Alcoholism Treatment Utilization Survey of 1980. (1982). In R. O'Brien & M. Chafetz (Eds.), *The encyclopedia of alcoholism* (pp.). New York: Facts on File.

[783] Connett, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, *15*(4), 585-589.

[784] Winick, C. (1990). The counselor in drug user treatment, *International Journal of the Addictions*, *25*(12a), 1479-502.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1981	Valle[785]	Counselors	Hospital-based inpatient alcoholism treatment facility	100%		
1981	Skuja[786]	Alcoholism counselors	US Navy alcohol treatment facility	50%		
1981	Stephen[787]	Alcohol and drug counselors	VA-funded counselor training program	92%		
1982	Camp & Kurtz[788]	Counselors working in alcohol and drug treatment	1979 national survey data	No data on recovery status; 37% were non-degreed		
1982	Hubbard, et al.[789]	Counselors	Tops Study	5 of 9 treatment sites reported no ex-users on staff		

[785] Valle, S. (1981). Interpersonal functioning of alcoholism counselors and treatment outcome. *Journal of Studies on Alcohol*, *42*, 783-790.

[786] Skuja. A. (1981). Treatment attitudes of recovered alcoholic counselors and nonalcoholic counselors. *Drug and Alcohol Dependence*, *8*(1), 61-68.

[787] Stephen, L.S. (1981). Pre- and post-test measurements of self-concept of trainees in an alcohol and drug counselor training program. *Journal of Alcohol and Drug Education*, *27*(1), 78-80.

[788] Camp, J. & Kurtz, N. (1982). Redirecting manpower for alcoholism treatment. In *Prevention, intervention and treatment: Concerns and models. Alcohol and health monograph*, (No. 3, DHHS Publication No. ADM 82-1192 pp. 371-397). Washington, D.C.: U.S. Government Printing.

[789] Hubbard, R.L., Pachal, J.V., Cavanaugh, E.R., Kirkpatrick, M.G., & Richardson, J.E. (1982). *Methodology for the TOPS Treatment Study*. Research Triangle Park, NC: Research Triangle Institute.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1982	Lawson[790]	Counselors	8 alcoholism treatment programs in IL	36%		
1983	Lawson et al.[791]	Counselors	Training institute	66%		
1983	Birch & Davis[792]	Alcoholism counselors	National survey	57%		
1984	LoSciuto, et al.[793]	Drug abuse counselors	16 addiction treatment programs in five cities	39%		
1984	Aiken, et al.[794]	Drug abuse counselors	16 addiction treatment programs in five cities	38%		
1985	Blum & Roman[795]	Occupational Program Consultant		33%		
1985-86	Ball (Cited in Winick, 1991)[796]	Counselors	7 MMT programs in three cities	31%		

[790] Lawson, G. (1982). Relation of counselor traits to evaluation of the counseling relationship by alcoholics. *Journal of Studies on Alcohol*, *43*, 834-839.

[791] Lawson, G., Petosa, R., & Peterson, J. (1982). Diagnosis of alcoholism by recovering alcoholics and nonalcoholics. *Journal of Studies on Alcohol*, *43*, 834-839.

[792] Birch & Davis Associates (1983). *Development of model professional standards for counselor credentialing*. Rockville, MD: NIAAA.

[793] LoSciuto, L.A., Aiken, L.S., Ausetts, M.A., & Brown, B.S. (1984). Paraprofessional versus professional drug counselors: Attitudes and expectations of counselors and their clients. *International Journal of the Addictions*, *19*(3), 233-252.

[794] Aiken, L., LoSciuto, L., Ausetts, M., & Brown, B.S. (1984a). Paraprofessional versus professional drug counselors: Diverse routes to the same role. *International Journal of Addictions*, *19*(2), 153-73.

[795] Blum, T. & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors. *Journal of Health and Social Behavior*, *26*(4), 365-378.

[796] Winick, C. (1991). The counselor in drug user treatment. *International Journal of the Addictions*, *25*(12a), 1479-502..

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1986	NAADAC[797]	Counselors	National NAADAC Survey	75%		
1987	McGovern & Armstrong[798]	Counselors	Texas Sample National Sample	70% 70%		
1987	Sobell & Sobell[799]	Counselors		76%		
1989	Mulligan et al.[800]	Counselors	Multiple Tx modalities	46% overall; 76% of those working in halfway houses; 76% of those working in detox programs; and 71% of those working in private inpatient programs		
1990	Williams, et al.[801]	Counselors	State survey in Kansas	54%		

[797] NAADAC (1986). *Survey of substance abuse counselors*. Arlington, VA: NAADAC: The Association of Addiction Professionals.

[798] McGovern, T. & Armstrong, D. (1987). Comparison of recovering and non-alcoholic counselors: A survey. *Alcoholism Treatment Quarterly*, *4*(1), 43-60.

[799] Sobell, M. & Sobell, L. (1987). Conceptual issues regarding goals in the treatment of alcohol problems. *Drugs and Alcohol*, *1*(2-3), 1-37.

[800] Mulligan, D.H., McCarty, D., Potter, D., & Krakow, M. (1989). Counselors in public and private alcoholism and drug abuse treatment programs. *Alcoholism Treatment Quarterly*, *6*(3-4), 75-89.

[801] Williams, E., Collyer, J., Crosby, G., Schaake, I., Hutchinson, J., McGeeney, T., et al. (1990). Counselor wellness and impaired practice: Survey results of the Kansas Alcoholism and Drug Addiction Counselors Association. *The Counselor*, *8*, 9, 39-40.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1991	Williams, et al.,[802]	Counselors			6o% reported having current/past intimate relationship, parent, child or other family member with addiction	
1991	Winick[803]	Counselors	Phoenix House	60% (compared with 80% in 1970s)		
1991	Leavy[804]	Certified alcoholism counselors	Survey of addiction counselors in Ohio	39%		
1992	Shipko & Stout[805]	Counselors	5 IP programs	33%		
1992	Kolpack[806]	Counselors	Wisconsin Survey	46%		
1992	Banken & McGovern[807]	Counselors	Texas conference participants, NAADAC leadership, and Counselor Editorial Board	37%		

[802] Williams, E., Bissell, L., Sullivan, E., & Handley, S. (1991). The co-dependent counselor. *Counselor, May-June*, 23-25.

[803] Winick, C. (1990). The counselor in drug user treatment. *International Journal of the Addictions*, *25*(12a), 1479-502.

[804] Leavy, R.L. (1991). Alcoholism counselors' perceptions of problem drinking. *Alcoholism Treatment Quarterly*, *8*(3), 47-55.

[805] Shipko, J. & Stout, C. (1992). A comparison of the personality characteristics between the recovering alcoholic and non-alcoholic counselor. *Alcoholism Treatment Quarterly, 9*, 207-214.

[806] Kolpack, R. (1992). Credentialing alcoholism counselors. *Alcoholism Treatment Quarterly, 9*, 97-112.

[807] Banken, J.A. & McGovern, T.F. (1992). Alcoholism and drug abuse counseling: State of the art considerations. *Alcoholism Treatment Quarterly*, *9*, 29-53.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1994	Mavis & Stöffelmayr [808]	Counselors	36 public addiction treatment programs	OP=9% Res=42%	OP=32% Res=46%	
1996	St. Germaine[809]	Counselors	National survey	52.6%		
1997	Roman & Blum[810]	Counselors	450 private treatment programs	50%		
1997	Hshieh et al.[811]	Counselors and psychologist	National Survey of NAADAC and APA	57% of addiction counselors; 13% of psychologists	11% of addiction counselors; 43% of psychologists	
1998	Roman & Blum[812]	Counselors	434 private treatment programs	Range from 33% to 53.5% across settings		
1999	Roman & Blum[813]	Counselors	400 private treatment programs	59.7%		
2002	Roman, Blum, & Johnson[814]	Counselors	305 private treatment programs	38%		

[808] Mavis, B.E. & Stoeffelmayr, B.E. (1994). Program factors influencing client satisfaction in alcohol treatment. *Journal of Substance Abuse*, *6*, 345-354.

[809] St. Germaine (1996). Dual relationships: A national study of addiction counselors' ethical beliefs and behaviors. *Alcoholism Treatment Quarterly*, *14*(2), 28-45.

[810] Roman, P. & Blum, T. (1997). *National Treatment Center Study: Summary Report*. Athens, GA: Institute for Behavioral Health.

[811] Hsieh, S., Hoffman, N.G., & Hollister, D.C. (1998). The relationship between pre-, during-, post-treatment factors, and adolescent substance abuse behaviors. *Addictive Behaviors*, *234*, 477-486.

[812] Roman, P. & Blum, T. (1998). *National Treatment Center Study: Summary Report (No. 3): Second Wave On-Site Results.* Athens, GA: Institute for Behavioral Health.

[813] Roman, P. & Blum, T. (1999). *National Treatment Center Study: Summary Report (No. 4): Results of Treatment Center Staff Questionnaires and New Center / Old Center Comparisons*. Athens, GA: Institute for Behavioral Health.

[814] Roman, P., Blum, T., & Johnson, A. (2002). *National Treatment Center Study: Summary Report (No. 5): Third Wave Results.* Athens, GA: Institute for Behavioral Health.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
1998	Culbreth & Borders[815]	Counselors	IP and OP treatment sites	40%		
1998	Stöffelmayr et al.[816]	Counselors	51 treatment programs	30%		
1998	Mondlick[817]	Counselors	Survey of 400 certified counselors in CT	48%		
1999	Stöffelmayr et al.[818]	Counselors	51 Treatment programs	32%		
2001	Nevada ATTC Workforce Survey [819]	Counselors		34%		
2001	Montana ATTC Workforce Survey[820]	Counselors		65%		
2001	Utah ATTC Workforce Survey[821]	Counselors		42%		
2001	Wyoming ATTC Workforce Survey[822]	Counselors		38%		

[815] Culbreth, J.R. & Borders, L.D. (1998). Perceptions of the supervisory relationships: A preliminary qualitative study of recovering and nonrecovering substance abuse counselors. *Journal of Substance Abuse Treatment*, *15*(4), 345-352.

[816] Stöffelmayr, B.E., Mavis, B.E., & Kasim, R.M. (1998). Substance abuse treatment staff: Recovery status and approaches to treatment. *Journal of Drug Education*, *28*(2), 135-145.

[817] Mondlick, L.E. (1998). Certified substance abuse counselors' perceptions of the effects of self-disclosure of their recovery status on the therapeutic relationship with substance abuse clients. Dissertation, New York University. *Dissertation Abstracts International*, *59*(05B), 2156.

[818] Stöffelmayr, B.E., Mavis, B.E., Sherry, L.A., & Chiu, C.W. (1999). The influence of recovery status and education on addiction counselors' approach to treatment. *Journal of Psychoactive Drugs*, *31*(2), 121-127.

[819] 2001-2004 Mountain West ATTC Workforce Study.

[820] 2001-2004 Mountain West ATTC Workforce Study.

[821] 2001-2004 Mountain West ATTC Workforce Study.

[822] 2001-2004 Mountain West ATTC Workforce Study.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2001	Colorado[823]	Counselors		34%		
2002	Osborn & Thombs (Ohio)[824]	Survey of addiction counselors in Ohio		37%		
2002	Kentucky ATTC Workforce Survey[825]	Director Staff				50% 51%
2002	Florida ATTC Workforce Survey[826]	Staff				45%
2002	Alabama ATTC Survey[827]	Staff				44%
2002	Ball, et al.[828]	Counselors	CTN Study	46%		
2003	Thomas et al.[829]	Addiction counselors	1,116 counselors from MA, TN, and WA	59.6%		
2003	Delaware ATTC Workforce Survey[830]	Director Staff				56% 36%

[823] 2001-2004 Mountain West ATTC Workforce Study.

[824] Osborn, C.J. & Thombs, D.L. (2002). Clinical orientation and sociodemographic characteristics of chemical dependency practitioners in Ohio. *Journal of Teaching in the Addictions, 1*, 5-18.

[825] RMC Corporation (2003). *Kentucky Workforce Survey 2002. Results of a statewide needs assessment of substance abuse treatment professionals*. Portland: Central East Addiction Technology Transfer Center**:** 53.

[826] Southern Coast ATTC 2002 & 2004 Workforce Survey.

[827] Southern Coast ATTC 2002 & 2004 Workforce Survey.

[828] Ball, S., Bachrach, K., DeCarlo, J., Farentinos, C., Keen, M., McSherry, T., et al. (2002). Characteristics, beliefs, and practices of community clinicians trained to provide manual-guided therapy for substance abusers. *Journal of Substance Abuse Treatment*, *23*, 309-318.

[829] Thomas, C.P., Wallack, S.S., Lee, S., McCarty, D., & Swift, R. (2003). *Journal of Substance Abuse Treatment*, *24*, 1-11.

[830] Knudsen, J. R., Williams, A. M., & Lucas, K. (2005). *Delaware Workforce Survey 2003. Results of a Statewide Needs Assessment of Behavioral Health Professionals.* Portland: Central East Addiction Technology Transfer Center**:** 57.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2003	NAADAC survey of early career counselors[831]	Counselors				61%
2003	Toriello & Benshoff[832]	Illinois	Survey of sample of certified addiction counselors in IL	33%		
2003	Mulvey et al.[833]	National substance abuse treatment workforce study		Recovery status not reported		
2004	Arkansas ATTC Workforce Survey[834]	Director Staff				25% 60%
2004	Missouri ATTC Workforce Survey[835]	Director Staff				13% 57%
2004	Oklahoma ATTC Workforce Survey[836]	Director Staff				56% 57%

[831] NAADAC, T. A. f. A. P. (2003). Year 2 Final Report. *A Survey of Early Career Substance Abuse Counselors.* Alexandria, VA: Retrieved from http://naadac.org/pressroom/files/Year2SurveyReport.pdf**:** 18.

[832] Torriello, P.J. & Benshoff, J.J. (2003). Substance abuse counselors and ethical dilemmas: The influence of recovery and education level. *Journal o f Addictions & Offender Counseling*, *23*(2), 83-98.

[833] Mulvey, K.P., Hubbard, S., & Hayashi, S. (2003). A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment*, *24*(1), 51-7.

[834] Wendler, A. M. & Murdock, T. B. (2005). *Substance abuse treatment workforce survey report 2004: Arkansas. Substance abuse treatment workforce survey report.* Kansas City: Mid-America Addiction Technology Transfer Center, in residence at University of Missouri-Kansas City**:** 40.

[835] Murdock, T. B., Wendler, A. M., & Hunt, S. C. (2005). *Substance abuse treatment workforce survey report 2004: Missouri.* Kansas City Mid-America Addiction Technology Transfer Center, in residence at University of Missouri-Kansas City**:** 39.

[836] Wendler, A. M., Hunt, S.C., & Murdock, T. B. (2005). *Substance abuse treatment workforce survey report 2004: Oklahoma*. Kansas City, Kansas City, MO: Mid-America Addiction Technology Transfer Center in residence at University of Missouri-Kansas City**:** 49.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2004	Tennessee ATTC Workforce Survey[837]	Director Staff Director Staff	Contract Agency Contract Agency Licensed Agency Licensed Agency			50% 61% 48% 40%
2004	New Hampshire ATTC Workforce Survey[838]	Direct service staff		47%		
2004	New Jersey ATTC Workforce Survey[839]	Directors Staff				50% 52%
2004	Rhode Island ATTC Workforce Survey[840]	Direct service staff		25%		
2004	Vermont[841]	Direct service staff		46%		

[837] RMC Corporation (2004). *Tennessee Workforce Survey 2004. Results of a Statewide Needs Assessment of Behavioral Health Professionals.* Portland, Central East Addiction Technology Transfer Center**:** 45.

[838] New England ATTC Workforce Survey, 2004.

[839] Northeast ATTC 2004 Workforce Survey.

[840] ATTC-NE (2004). Rhode Island Direct Service Providers: Summary of Findings. *Workforce Survey Results.* Providence, RI: Addiction Technology Transfer Center of New England in collaboration with the New England Institute of Addiction Studies and the State of Rhode Island, Department of Mental Health**:** 4.

[841] ATTC-NE (2004). Vermont Direct Service Providers: Summary of Findings. *Workforce Survey Results.* Providence, RI: Addiction Technology Transfer Center of New England in collaboration with the New England Institute of Addiction Studies and the State of Vermont's Department of Health, Division of Alcohol and Drug Abuse Programs**:** 4.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2004	Connecticut ATTC Workforce Survey[842]	Direct service staff		51%		
2004	Massachusetts ATTC Workforce Survey[843]	Direct service staff		32%		
2004	Maine ATTC Workforce Survey[844]	Direct service staff		49%		
2004	Florida ATTC Workforce Survey[845]	Directors		36%		
2003-2004	Arizona ATTC Workforce Survey[846]	Directors Staff		39% 60%		
2003-2004	California ATTC Workforce Survey[847]	Directors Staff		54% 63%		

[842] ATTC-NE (2004). Connecticut Direct Service Providers: Summary of Findings. Providence, RI: Addiction Technology Transfer Center of New England**:** 4.

[843] ATTC-NE (2004). Massachusetts Direct Service Providers: Summary of Findings. *Workforce Survey Results.* Providence, RI: Addiction Technology Transfer Center of New England**:** 4.

[844] ATTC-NE (2004). Maine Direct Service Providers: Summary of Findings. *Workforce Survey Results.* Providence, RI: Addiction Technology Transfer Center of New England**:** 4.

[845] Wagner, E. F. & Tarolla, Susan M. (2004). Southern Coast Addiction Technology Transfer Center (SCATTC). *2004 Florida Agency Director Workforce Survey Report*_G. D. Dixon. Tallahassee, Southern Coast Addiction Technology Transfer Center (SCATTC)**:** 44.

[846] PSATT (2004). Arizona's Substance Abuse Workforce. *PSATTC Workforce Survey Summary Report* Phoenix, AZ: Pacific Southwest Addiction Technology Transfer Center (PSATTC)**:** 4.

[847] PSATTC (2004). California's Substance Abuse Workforce. *PSATTC Workforce Survey Summary Report.* Phoenix, AZ: Pacific Southwest Addiction Technology Transfer Center (PSATTC)**:** 4.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2003-2004	New Mexico[848]	Directors Staff		17% 59%		
2004	McGovern, et al.[849]	Counselors	Survey of 89 counselors			
2005	Arfken, et al.[850]	Counselors	CTN Study	37.1% CTN Counselors; 62.2% Non-CTN counselors		
2005	Fuller, et al.[851]	Counselors	OP treatment centers in five NE states	30.2%		
2005	Knudsen, et al., 2005[852] 45.5%	Counselors	Survey of 2,298 counselors in public and private Tx programs	45.5%		

[848] PSATTC (2004). New Mexico's Substance Abuse Workforce. *PSATTC Workforce Survey Summary Report.* Phoenix, AZ: Pacific Southwest Addiction Technology Transfer Center (PSATTC)**:** 4.

[849] McGovern, M.P., Fox, T.S., Xie, H., & Drake, R.E. (2004). A survey of clinical practices and readiness to adopt evidence-based practices: Dissemination research in an addiction treatment system. *Journal of Substance Abuse Treatment, 26*, 305-312.

[850] Arfken, C.L., Agius, E., Dickson, M.W., Anderson, H.L., & Hegedus, A.M. (2005). Clinicians' beliefs and awareness of substance abuse treatments in research and non-research affiliated programs. *Journal of Drug Issues, 35*, 547-558.

[851] Fuller, B.E., Riechkmaan, T., McCarty, D., Smith, K.W., & Levine, H. (2005). Adoption of naltrexone to treat alcohol dependence. *Journal of Substance Abuse Treatment, 28*, 273-280.

[852] Knudsen, H.K., Ducharme, L.J., Roman, P.M., & Link, T. (2005). Buprenorphine diffusion: The attitudes of substance abuse treatment counselors. *Journal of Substance Abuse Treatment, 29*, 95-106.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2005	Maryland ATTC Workforce Survey[853]	Director Staff Director Staff	Funded Agency Funded Agency Non-funded Agency Non-funded Agency			56% 56% 44% 56%
2005	Alaska ATTC Workforce Survey[854]	Directors Clinicians		13% 36%	21% 14%	
2005	Idaho ATTC Workforce Survey[855]	Directors Clinicians		46% 38%	9% 14%	
2005	Oregon ATTC Workforce Survey[856]	Directors Staff		13% 36%	21% 14%	
2005	Washington ATTC Workforce Survey[857]	Directors Staff		44% 48%	11% 10%	

[853] Knudsen, J. R. W. & Williams, A.M. (2005). Maryland Workforce Survey 2005; *Results of a Statewide Needs Assessment of Behavioral Health Professionals*. Portland: Central East Addiction Technology Transfer Center and Mid-Atlantic Addiction Technology Transfer Center and Central East Addiction Technology Transfer Center**:** 51.

[854] NFATTC (2005). Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey: Executive Summary for Alaska. *The Current State of Addiction Treatment: Substance Abuse Workforce Survey 2005 Executive Summaries*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center**:** 6.

[855] NFATTC (2005). Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey: Executive Summary for Idaho. *The Current State of Addiction Treatment: 2005 NFATTC Substance Abuse Treatment Workforce Survey*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center**:** 6.

[856] NFATTC (2005). Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey: Executive Summary for Oregon. *The Current State of Addiction Treatment.* Salem, OR: Northwest Frontier Addiction Technology Transfer Center**:** 6.

[857] NFATTC (2005). Results from the 2005 NFATTC Substance Abuse Treatment Workforce Survey: Executive Summary for Washington. *The Current State of Addiction Treatment*. Salem, OR: Northwest Frontier Addiction Technology Transfer Center**:** 6.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2005	Olmstead et al.[858]	Counselors	National Treatment Center Study	51%		
2005	Toriello, et al.[859]	Counselors	New Orleans study	24%		
2006	Knudsen et al.[860]	Counselors	253 therapeutic communities	57%		
2006	McCollum[861]	Counselors	Sample of addiction counselors from seven states	43%		
2006	Sias, et al.[862]	Counselors	188 addiction counselors in VA	36%		
2006	Kirby, et al.[863]	Counselors	253 counselors from five states	24%		
2006	Thomas & Miller[864]	Counselors	84 counselors in SC	21%		

[858] Duplicate of footnote 749. Do you want this in the table twice?

[859] Toriello, P.J., Roahen-Harrison, S., Rice, J., Ager, R., Morse, E.V., Morse, P., et al. (2005). The relationship between addictions counselors' clinical orientations and their readiness to change counseling techniques. *Journal of Addictive Diseases*, *24*(1)Supplement, 75-92.

[860] Knudsen, H.K., Ducharme, L.J., & Roman, P.M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment*, *3*, 173-180.

[861] McCollum. V. (2006). Beliefs of board certified substance abuse counselors regarding multiple relationships. *Journal of Mental Health Counseling, 28*, 84-94. Retrieved August 25, 2008 from http://www.thefreelibrary.com/Beliefs+of+board+certified+substance+abuse+counselors+regarding...-a0141212922.

[862] Sias, S.M, Lambie, G.W., & Foster, V.A. (2006). Conceptual and moral development of substance abuse counselors: Implications for training. *Journal of Addictions and Offender Counseling*, *26*(2), 99-110.

[863] Kirby, K. C., Benishek, L. A., Dugosh, K. L., & Kerwin, M. E. (2006). Substance abuse treatment providers' beliefs and objections regarding contingency management: Implications for dissemination. *Journal of Substance Abuse Treatment, 85,* 19-27.

[864] Thomas, S. E. & Miller, P.M. (2007). Knowledge and attitudes about pharmacotherapy for alcoholism: A survey of counselors and administrators in community-based addiction treatment centers. *Alcohol and Alcoholism, 42*(2), 113-118.

Year	Study	Role	Setting	In Recovery	Family Recovery	Personal/ Family Recovery Experience
2006	Simmons et al.[865]	Survey of 72 addiction counselors		46%		
2007	Knudsen et al.[866]	Counselors	NIDA CTN study	44%		
2007	Knudsen, Ducharme & Roman Am J of Addict[867]	Survey of 2,306 addiction counselors	42.66%-53.22% across four study subgroups			
2007	Rieckmann et al.[868]	376 counselors	21% in OP 22.3% in MTT 64.5% in Res Rehab			
2008	Thomas et al.[869]	Counselors	84 counselors	16% and 26% in two study groups		

[865] Simons, L., Jacobucci, R., & Houston, H. (2006). Novice, seasoned and veteran counselors' views of addiction treatment manuals: The influence of counselor characteristics on manual usefulness. *Journal of Psychoactive Drugs*, *38*(4), 483-91.

[866] Knudsen, H.K., Ducharme, L.J., & Roman, P.M. (2007). Research participation and turnover intention: An exploratory study of substance abuse counselors. *Journal of Substance Abuse Treatment*, *33*, 211-217.

[867] Knudsen, H.K., Ducharme, L., & Roman, P.M. (2007). Research network involvement and addiction treatment center staff: Counselor attitudes toward buprenorphine. *The American Journal on Addictions*, *16*, 365-371.

[868] Rieckmann, T., Daley, M., Fuller, B.E., Thomas, C.P., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications for treatment of opioid dependence. *Journal of Substance Abuse Treatment*, *32*, 207-215.

[869] Thomas, S.E., Miller, P.M., Randall, P.K., & Book, S.W. (2008, in press). Improving acceptance of naltrexone in community addiction treatment centers: A pilot study. *Journal of Substance Abuse Treatment.*



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.L., Evans. A.C., Ali, S., Abrahams, I. & King, J. (2009). The recovery revolution: Will it include children and adolescents? Philadelphia: Department of Behavioral Health and Mental Retardation Services. Posted at **www.williamwhitepapers.com**

The Recovery Revolution: Will it include children, adolescents, and transition age youth?

William L. White, M.A., Arthur C. Evans, Jr., Ph.D., Sadé Ali, M.A., Ijeoma Achara-Abrahams, Ph.D., & Joan King, APRN, BC

Executive Summary

Systems transformation efforts to shift addiction treatment from a model of acute stabilization to a model of sustained recovery management and to nest addiction treatment within a larger recovery-oriented system of care are underway at federal, state, and local levels, but these innovations to date have focused on the redesign of adult services. This paper explores the potential and limitations of recovery as an organizing concept for services to children, adolescents, and transition age youth, and offers recommendations on how services for these populations can be integrated into recovery- and resiliency-focused, behavioral health care systems transformation efforts.

Recovery Revolution Defined

- Since 2004, the City of Philadelphia has been engaged in a recovery-focused behavioral health care systems transformation process that has mobilized the community around a recovery vision and begun aligning concepts, service practices, and contexts (e.g., regulatory policies, funding mechanisms) to support that vision.
- Federal, state, and local behavioral health policy and planning bodies are now evaluating the extent to which recovery can be used as an organizing concept for child and adolescent (C & A) services.
- There is growing consensus to create a recovery-oriented system of care for youth that is family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment.
- Questions remain about the potential advantages and disadvantages of the recovery concept applied to C & A services and how that concept can be integrated with the existing concepts that have been used to guide the design of C & A services.
- These questions will be explored as they relate to *children*, *adolescents*, and *transition age-youth.*

Historical Context: Recovery and Age of Onset of Alcohol and Drug Use

- The most socially and clinically significant American drug trend of the past century is the lowered age of onset of alcohol and other drug use.
- Lowered age of initial AOD use is linked to greater risk of developing a substance use disorder, the speed of problem progression and severity of consequences, and greater levels of post-treatment relapse.
- The average age of onset of AOD use of adolescents entering addiction treatment is now below age 13.
- The concept of recovery is more applicable to children, adolescents, and transition-age youth now than at any previous time in the country's history.

Family Recovery

- Child development can be adversely affected by AOD-related problems of their parents or siblings, and children in AOD-affected families are at increased risk for developing such problems as well as experiencing other adverse developmental outcomes.
- The recovery of a parent with AOD-related problems enhances the health and developmental outcomes of his or her children.
- Interventions are available that enhance the recovery and resilience of children negatively impacted by parental substance dependence.

Recovery of Adolescents and Transition Age Youth\

- In 2008, 8% of youth aged 12-17 and 21% of transition age youth met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one in ten youth received specialized addiction treatment.
- There are more than 4,900 treatment programs that specialize in the treatment of adolescent substance use disorders. There has also been an increase in youth-focused recovery mutual aid meetings.
- The earlier the intervention for a substance use disorder (in terms of both age and months/years of use), the better the long-term recovery outcomes.
- There are evidence-based, brief therapies that are effective for many substance-involved adolescents, but most adolescents are precariously balanced between recovery and relapse in the months following such therapy.
- Recovery stability is enhanced by sustained post-treatment monitoring, support, and if needed, early re-intervention, but such extended care and support is rare.
- The concept of recovery seems to be a viable one for adolescents seeking to reconstruct their lives following significant and sustained AOD-related problems.

Conceptual Frameworks for Organizing Child and Adolescent Services

- The concepts of "system of care," "wraparound services," "positive youth development," and "resilience" have served as organizing frameworks for C & A services in recent decades.
- Resilience is the achievement of positive developmental outcomes in spite of personal and environmental risk factors.
- Resilience-based systems of youth development seek to reduce risk factors and increase protective factors at personal, family, and environmental levels.

- Resistance is: 1) an innate hardiness that allows one to be exposed to an infectious agent without becoming ill, and/or 2) the act of desisting or ceasing AOD use as an act of cultural or political survival.
- Recovery from a substance use disorder entails three critical ingredients: sobriety, global health (physical, cognitive, emotional, relational, spiritual), and citizenship.
- These elements of recovery have yet to be fully defined for youth.

Recovery Management and Recovery-Oriented Systems of Care

- *Recovery management* (RM) is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.
- *Recovery-oriented systems of care* (ROSC) encompass the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families affected by AOD problems and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes.
- Approaches to RM and ROSC for adults and for youth share many elements in common.
- Efforts are currently underway (as this report indicates) to identify what distinctive changes in services for children, adolescents, and transition age youth occur within the movement to RM and ROSC.

Shared Characteristics of Organizing Concepts

- Rather than think of recovery and resilience in either/or terms, it may be helpful to think of systems transformation guided by both resilience and recovery.
- Child and family advocates in many places have embraced these concepts as complementary.

Primary Prevention, Early Intervention, Treatment, and Recovery Support

- Addiction treatment and recovery support services for parents constitute a strategy of prevention for their children.
- These strategies can be further amplified by involving children in the treatment of their parent and by providing specialized services designed to enhance the child's recovery from the developmental insults of parental addiction and to enhance the child's future resilience and resistance related to AOD-related problems.
- The treatment of every adult parent should include child-focused prevention and early intervention services aimed at breaking the intergenerational transmission of AOD-related problems.
- RM and ROSC involve an integration of primary prevention, early intervention, treatment, and recovery support services.

Recovery Concept and Children: Advocates

- Advocates of applying the recovery concept to C & A services extol the concept's holistic, developmental perspective; emphasis on hope, empowerment, and choice; integration of spirituality as a healing/protective force; emphasis on thriving rather than just symptom remission; compatibility with system of care and positive youth development approaches to youth service design; inclusion of such issues as historical trauma and social stigma; and its emphasis on the role of social connectedness in adolescent health.

Recovery Concept and Children: Critics

- Critics of applying the recovery concept to C & A services contend that recovery: is misapplied to children because of its meaning of returning to a previous level of functioning; brings with it the social stigma attached to addiction; lacks a holistic, developmental perspective because of its “disease” trappings; and works only if integrated with the concept of resilience.

The Philadelphia Focus Groups

- Focus groups with providers, parents, and youth felt that recovery and resilience were compatible concepts that both called for developmentally-informed models of care, family inclusion/direction and leadership, peer support and leadership, a continuum of support, community integration and mobilization of community recovery/resiliency support resources, trauma-informed care (and addressing violence within the trauma framework), and culturally competent care.
- A group of youth much discussed in the Philadelphia focus groups was transition age youth who were “aging out” of the child service system with little transitional support when they were no longer eligible to continue receiving services. It was hoped that new approaches to such transition planning could be developed given the ROSC emphasis on long-term, stage-appropriate recovery support.

The Voices of Youth

- Voices from the youth focus groups pleaded for a system of care that would see them as individuals rather than a disorder and relate to them from a position of respect and authenticity.

Summary and Recommendations

- The report ends with a set of recommendations in the following areas: concepts and language of systems transformation, representation and leadership, recovery visibility of youth, collaboration and partnership, a continuum of (personal/family/community) recovery support, practice guidelines, assessment and treatment/recovery planning, recovery-focused treatment, youth-focused peer recovery culture, and evaluation of effects of systems transformation on C & A and C & A Service Providers.
- These recommendations are intended as a framework for continued discussions regarding the future of C & A services within the City of Philadelphia.

The Recovery Revolution:
Will it include children, adolescents, and transition age youth?

William L. White, M.A., Arthur C. Evans, Jr., Ph.D., Sadé Ali, M.A.,
Ijeoma Achara-Abrahams, Ph.D., & Joan King, APRN, BC

Comprehensive systems to facilitate recovery for adults with substance abuse and/or mental health concerns have been conceptualized and operationalized in a number of states and communities across the United States and in other countries. To date there has been little discussion or research on how these adult-focused concepts apply to adolescents.[1]

The governing concepts of the addictions field are rapidly shifting from a focus on pathology and professional treatment to the lived experience of long-term recovery. Phrases such as *recovery management* (RM) and *recovery-oriented systems of care* (ROSC) reflect a paradigmatic shift in the design and delivery of addiction treatment. *Systems transformation* efforts reflecting this new long-term recovery perspective are underway at federal, state, and local levels.[2] These initiatives are generating considerable excitement within the addictions field, but are to date limited by their emphasis on the redesign of adult addiction treatment and innovations related to peer-recovery support services for adults. The purpose of this paper is to explore the potential and limitations of recovery as an organizing concept for services to children, adolescents, and transition age youth. The paper explores a variety of potential organizing concepts and ends with a series of recommendations on how children, adolescent, and transition age youth services can be fully integrated into recovery- and resiliency-focused, behavioral health care systems transformation efforts.

Recovery Revolution Defined

For the past five years, the City of Philadelphia has been at the center of two national shifts in behavioral health care. The first is the emergence of *recovery* as an organizing concept for the design and delivery of addiction treatment and other behavioral health care services.[3] The second is an effort to extend addiction treatment from models of acute biopsychosocial stabilization or palliative care to a model of active and sustained recovery management[4] and to

---

[1] Cavanaugh. D., Goldman, S., Friesen, B. and Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use and co-occurring mental health disorders*. Prepared for the CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[2] White, W. (2008). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[3] 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. White, W. (2005) Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*(1), 3-15. White, W. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

[4] McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695; 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.

nest these services within larger "recovery-oriented systems of care."[5] The contextual influences that set the stage for this "recovery revolution" include the growth, philosophical diversification, and geographical dispersion of recovery mutual aid societies (including online recovery communities); the cultural and political awakening of people in recovery from behavioral health disorders via a renewed advocacy movement; and increased recovery community building activities, e.g., the growth of grassroots recovery community organizations, community recovery centers, recovery homes, recovery schools, recovery industries, and recovery ministries.[6]

In 2004, the City of Philadelphia committed itself to a major recovery-focused transformation of its behavioral health care system under the new leadership of Dr. Arthur Evans, Jr. Table 1[7] identifies several distinguishing elements of the "Philadelphia Model" of behavioral health care systems transformation.

Table 1: Creating a Recovery-Oriented System of Care: The Philadelphia Model

System Dimension	Philadelphia Model
Recovery Vision	Resources are allocated to support the recovery vision (wellness, wholeness, quality, and meaningfulness of life) for individuals, families, and neighborhoods. All policy-makers and clinical decision-makers undergo ongoing, recovery-focused training and supervision.
Varieties of Recovery Experience	Service planners and providers acknowledge the legitimacy of multiple pathways and styles of long-term recovery from behavioral health disorders and promote a philosophy of choice within their service relationships.
Systems Level Recovery Management	Behavioral health care is managed by a publicly-owned entity responsible for the effective stewardship of public behavioral health care dollars and the strategic allocation of resources to support the long-term recovery of individuals and families whose lives have been disrupted by behavioral health disorders.
Behavioral Health Care Integration	Recovery is used as a conceptual bridge for the increased integration of professionally-directed mental health services, professionally-directed addiction treatment services, peer-based recovery support services, and primary health care.
Systems Integration	Federal, state, county, and municipal resources are coordinated to generate increased resources, strategically allocate resources, and provide regulatory relief.
Service Accessibility	Service entry is accessible, efficient, respectful, and warmly welcoming: all system elements are devoted to the goal of rapid and gracious service engagement.

[5] White, W. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[6] White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

[7] Excerpted from McLaulin, B., Evans, A.C., & White, W. (2009). The role of addiction medicine in a recovery-oriented system of care. Unpublished manuscript.

Global Assessment	Assessment is comprehensive, strengths-based, continual, family-inclusive, and encompasses assessment of each client's recovery environment.
Service Quality and Responsiveness	Services are developmentally appropriate, gender-specific, culturally competent, trauma-informed, family-focused, and evidence-based.
Indigenous Resources	Services at all levels of care include assertive linkage to indigenous communities of recovery (recovery support groups) and recovery community service institutions (recovery community centers, recovery homes, recovery ministries, recovery advocacy organizations).
Continuity of Support	All primary treatment services are followed by post-treatment monitoring and support, stage-appropriate recovery education, active recovery coaching, and when needed, early re-intervention.
Systems Performance Monitoring and Evaluation	Recovery-focused systems performance data and the ongoing guidance of key stakeholders are used to guide the continued systems transformation process.
Systems Health	The ability of a behavioral health care system to enhance the health of those it serves is only as good as the health of service providers and the service infrastructure. Active efforts are made to enhance the health and performance of service providers and service organizations.

Table 2[8] summarizes key ideas that have guided this process of system-wide change.

Table 2: Philadelphia System Transformation Implementation Principles/Strategies

1. Partnership: Relationships within the system—from service relationships to institutional relationships—shift from authority-based to respect-based and emphasize stakeholder representation, participation, collaboration, and multi-directional communication.
2. New Ideas, New Language, New Technologies: Systems transformation is driven by a set of kinetic (change-eliciting) ideas, a new language, and new planning and service technologies that are recovery-focused.
3. Core Values: Decisions are based on the values of hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach.
4. Openness and Transparency: Decisions at all levels of the system—from clinical decisions to policy and funding decisions—are transparent and consistent with previously defined values, policies, and plans.
5. Planned Synergism: Multiple staged initiatives are used to complement one another to achieve magnified effects.
6. Minimalism: Existing structures are used or renewed when possible; the goal is the minimal level of organization needed to achieve a task; wide use of short-

[8] Excerpted from McLaulin, B., Evans, A.C., & White, W. (2009). The role of addiction medicine in a recovery-oriented system of care. Unpublished manuscript.

term ad hoc groups to study, decide, design, create, and disband; preference for development and use of local expertise.

7. Management of Resistance: Resistance to change at all levels is viewed as a normal part of the systems change process and is actively managed.
8. Change Facilitation: System transformation is facilitated by training, process consultation, and technical assistance at all levels of the service delivery system.

As these tables illustrate, the behavioral health care systems transformation process in Philadelphia involves efforts aimed at conceptual alignment (core values and principles), contextual alignment (system policies and relationships), and practice alignment—all directed toward support of long-term recovery for individuals and families. The history, goals, and strategies of this process have been described in a series of earlier publications.[9]

Those readers with any significant tenure in health and human service systems will have witnessed the rise and fall of many newly proclaimed organizing concepts. Seen in this historical context, it is difficult to determine whether an emerging concept adds something fundamentally new and valuable or whether it represents a repackaging of old ideas into a new rhetoric.[10] Huffine[11] has raised the question of whether all this new rhetoric—transformation, resilience, recovery, evidence-based practices—constitutes a sign of real change or "the latest ways to put lipstick on a pig"—a cosmetic attempt to beautify failing service systems. Even the most viable of concepts can be lost in the rapidly evolving arena of behavioral health care. Early discussions of systems transformation always evoke feelings of déjà vu and skepticism.

> *I've lived through many administrations and the focus always changes: this month we're supposed to be doing XXX and next month it's YYY. What's going to happen when the focus changes away from recovery and resilience?*[12]

[9] Achara-Abrahams, I., Kenerson, J., & Evans, A.C. (in press). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. In J. Kelly, & W. White (Eds.), *Addiction recovery management: Theory, science and practice*. Totowa., New Jersey: Humana Press, Inc. DBH/MRS (2007). *Recovery-focused transformation of behavioral health services in Philadelphia: A declaration of principles and a blueprint for change*. Philadelphia: Department of Behavioral Health and Mental Retardation Services. Retrieved from http://www.phila.gov/dbhmrs/initiatives/index.html. DBH/MRS (2007). *An integrated model of recovery-oriented behavioral health care.* Philadelphia: Department of Behavioral Health and Mental Retardation Services. Retrieved from http://www.phila.gov/dbhmrs/initiatives/INT_index.html. Evans.A.C., & Beigel, A. (2006). *Ten critical domains for system transformation: A conceptual framework for implementation, evaluation and adaptation*. Presented at the 16th Annual Conference on State Mental Health Agency Services Research, Program Evaluation & Policy, February, Baltimore, MD. Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Retrieved June 26, 2007 from http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf. Lamb, R., Evans, A.C., & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience. Philadelphia: Department of Behavioral Health and Mental Retardation Servies; White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

[10] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[11] Huffine, C. (2006). A new concept of mental health: A focus on strengths. *Iceberg Newsletter*, September, 2-4.

[12] Philadelphia Caregiver Focus Group Participant, 2009

Why focus practice guidelines on recovery and resilience? Ten years from now it will be changing. What are we doing to look and plan for future changes?[13]

An effective organizing concept—what Room[14] calls a "governing image"—must "work" at multiple levels. It must help individuals and families impacted by severe AOD problems make sense of their lives via processes of story construction and storytelling, e.g., "disclose in a general way what we used to be like, what happened, and what we are like now".[15] It must provide a framework to guide the service activities of addiction professionals and recovery support specialists. It must provide a framework for service program design, development, and replication. It must guide policy makers and funding organizations in their macro-level responses to AOD problems. It must help the general public understand, prevent, and respond to such problems. A concept must achieve all of these things across diverse populations and cultural contexts and prove adaptable to changing conditions over time.

It is then not surprising that any governing image used to respond to an intractable problem is inherently unstable.[16] The inevitable imperfection of fit—concepts that work at some but not all of these levels, concepts that work for some populations and within some cultures but not others, concepts that once seemed to work in the past but seem not to presently work—has generated a long history of conceptual instability within the AOD problems arena in the United States.

As the Philadelphia systems transformation process unfolded over the past five years, questions were raised about how this transformation process and the concept of recovery upon which it rests applies to particular service populations and to particular service modalities. For example:

- Where do primary prevention and early intervention services fit within an ROSC?
- What are the shared and distinguishing characteristics of the concepts of resilience and recovery?
- Where does medication-assisted treatment fit within a recovery-oriented system of care—if at all?
- What roles, if any, do harm reduction (e.g., needle exchange programs) and risk reduction (e.g., DUI programs) play within a recovery-oriented system of care?

As the change process within Philadelphia's behavioral health care system proceeds, there is growing consensus that it needs to go "deeper" (achieving greater depths of change in policies and service practices) and "wider" (embracing service populations and service organizations that have not been fully involved in the transformation process). Questions like the above and the question of how all this relates to children and adolescent services are part of this "deeper" and "wider" process.

The exploration of how systems transformation would affect children and adolescent services was raised early in the transformation process in Philadelphia. A child and adolescent (C & A) subcommittee was created within the Office of Addiction Services Advisory Board to

[13] Philadelphia Caregiver Focus Group Participant, 2009

[14] Room, R. (1978). *Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

[15] Alcoholics Anonymous (1939). Proposal to form the One Hundred Men Corporation to publish the book *One Hundred Men*. (Reprinted 1991). Wheeling, WV: The Bishop of Books.

[16] Room, R. (1978). *Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

assure the inclusion of goals and objectives related to C & A services.[17] As the transformation process proceeded, greater concern has been voiced about whether the concept of recovery adds anything new to alcohol- and other drug-related (AOD) services for children, adolescents, transition age youth, and their families as well as the future of C & A services within an ROSC.

The concerns raised in Philadelphia about application of the recovery concept to children's services have been mirrored in a series of national meetings. In 2005, the Center for Substance Abuse Treatment (CSAT) hosted a recovery summit that included discussion of the application and potential misapplication of the concept of recovery to adolescents. In November 2008, a national "recovery consultative session" was hosted by CSAT and the Center for Mental Health Services (CMHS) to explore the design of a "recovery-oriented system of care for adolescents and transition age youth" with a substance use or co-occurring mental health disorder. In March 2009, a "national dialogue on families of youth with substance use addiction" engaged affected families and representatives from the Substance Abuse and Mental Health Services Administration (SAMHSA). The latter two meetings addressed problems of service access and quality for substance-affected youth and families, the untoward effects of addiction-related social stigma, and the need for a broad and sustained spectrum of clinical and recovery support services to buttress adolescent recovery through the developmental transition into adulthood. Meeting participants called for a recovery-oriented system of care for youth to be family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment.[18]

It is noteworthy that the appropriateness and degree of applicability of recovery as an organizing concept for behavioral health services for children and adolescent services tend not to be raised at national, state, or local levels as a major concern until systems transformation processes are well underway.[19] This paper is intended as a stimulus for continued discussion of this issue in Philadelphia and at a national level. It will review scientific studies and professional commentaries on recovery as an organizing concept for services to youth, summarize the results of national and local focus groups that have been hosted to address this question, and offer recommendations to guide our continued work in Philadelphia.

Recovery-related concepts require substantial adaptation across the developmental life cycle.[20] To add specificity to the coming discussions, we will apply these concepts and principles to three distinct developmental groups: *children*, *adolescents*, and *transition age-youth* (also referred to as *emerging adults*).[21] The precise definitions of the three groups vary considerably in the professional and popular literature. In this paper, children will be defined as persons under the age of 13; adolescents will be defined as persons between the ages of 13 and 17; and transition age youth will be defined as persons between the ages of 18 and 25.

---

[17] See http://www.dbhmrs.org/assets/Forms--Documents/4.2.1.2-OAS-Goals-Objectives-Board-Final-Draft-20080620.pdf

[18] Cavanaugh. D., Goldman, S., Friesen, B., & Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use and co-occurring mental health disorders*. Prepared for the CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[19] Davidson, L., O'Connell, M.J., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, *57*(5), 640-645. Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Retrieved June 26, 2007 from http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf. Kirk, T. (2007). Creating a recovery-oriented system of care. In W. White (Ed.), *Perspectives on systems transformation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[20] White, W. (2006). Recovery across the life cycle. *Alcoholism Treatment Quarterly, 24*(1/2), 185-201.

[21] Tanner, J.L. (2006). Recentering during emerging adulthood: A critical turning point in life span human development. In J.J. Arnett, & J.L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (pp. 21-55). Washington D.C.: American Psychological Association.

Historical Context: Recovery and Age of Onset of AOD Use

There is a long history of concern about alcohol and other drug use among youth in the United States,[22] but the thought of a person in recovery from alcohol or other drug addiction has not historically elicited images of children or adolescents. Until recently, the primary focus on children has been in the arenas of prevention and early intervention and the effects of parental AOD use on children. That focus began to change with the rise of juvenile narcotic addiction following World War II and shifted further during the dramatic rise of youthful drug experimentation in the 1960s and 1970s.[23]

The most socially and clinically significant American drug trend of the past century is the lowered age of onset of alcohol and other drug use.[24] By the early 1990s, more than one third of drug-using youth incarcerated within state-operated juvenile facilities reported onset of drug use before age 12 (19% before age 10).[25] A 2005 study of children in foster care found that more than one-third of older children met diagnostic criteria for a substance use disorder.[26] A 2004 study—the largest randomized trial of adolescent treatment ever conducted—revealed that 85% of adolescents entering addiction treatment in the United States begin regular use of alcohol and other drugs before age 15.[27] Seen as a whole, age-related prevalence for substance use disorders sharply rises after age 12 and peaks between ages 18-23, suggesting that the prodromal period for these disorders often spans late childhood and early and middle adolescence.[28] Adding to this import is the finding that the earlier age at which a substance use disorder is treated, the better the long-term outcome.[29]

---

[22] White, W. (1999). The history of adolescent alcohol, tobacco and other drug use. *Student Assistance Journal*. *11*(5), 16-22.

[23] White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor, 3*(2), 20-23.

[24] White, W., Godley, M., & Dennis, M. (2003). Early onset of substance abuse: Implications for student assistance programs. *Student Assistance Journal, 16*(1), 22-25.

[25] U.S. Department of Justice, Bureau of Justice Statistics. (1994). *Drugs and Crime Facts, 1994.* Retrieved from http://www.ojp.usdoj.gov/bjs/dcf/contents.htm.

[26] Vaughn, M., Ollie, M., McMillen, C., Scott, L., & Munson, M. (2005, January). *Patterns of substance use among older youth in foster care*. Presented at the Society for Social Work and Research Conference, Miami, FL. Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[27] Dennis, M.L., Godley, S.H., Diamond, G.S., Tims, F.M., Babor, T., Donaldson, J., Liddle, H., Titus, J.C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R.R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*, 197-213.

[28] Dennis, M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer. Enoch, M. (2006). Genetic and environmental influences on the development of alcoholism. *Annals of the New York Academy of Science*, *1094*, 193-201. Palmer, R.H.C., Young, S.E., Hopfer, C.J., Corley, R.P., Stallings, M.C., Crowley, T.J., & Hewitt, J.K. (2009). Developmental epidemiology of drug use and abuse in adolescence and young adulthood: Evidence of a generalized risk. *Drug and Alcohol Dependence*, *102*, 78-87.

[29] Dennis, M.L., Scott, C.K., Funk, R., & Foss, M. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*(Supplement 1), S51-S62. M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer.

It is difficult to overemphasize the clinical and social significance of lowered age of onset of AOD use, particularly pre-adolescent onset, and the importance of early prevention and early intervention services. Lowered age of initial AOD use is linked to:

- increased probability of subsequent multiple drug use,[30]
- increased risk of developing a substance use disorder,[31]
- telescoping of the progression of AOD-related problems,[32]
- greater problem severity and complexity—including greater cognitive impairment, liver dysfunction, and probability of a co-occurring psychiatric illness,[33]
- increased risk of school failure,[34]
- increased lifetime risk of accidents while under the influence of alcohol,[35]
- increased risk of perpetration of and victimization by alcohol-related violence,[36] and
- compromised intervention outcomes, e.g., decreased probability of discontinuance of drug use, less help-seeking, and greater post-intervention relapse.[37]

---

[30] Kandel, D.B. (1982). Epidemiological and psychosocial perspectives on adolescent drug use. *Journal of American Academic Clinical Psychiatry*, *21*, 328-347. McGue, M., Iacono, W.G., Legrand, L.N., & Elkins, L. (2001). Origins and consequences of age at first drink: I. Associations with substance-use disorders, disinhibitory behavior and psychopathology, and P3 amplitude. *Alcoholism: Clinical and Experimental Research*, *25*, 1156-1165.

[31] Chou, S. P., & Pickering, R. P. (1992). Early onset of drinking as a risk factor for lifetime alcohol-related problems. *British Journal of Addiction*, *87*, 1199-1204. Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse*, *9*, 103-110. Dennis, M. L., Babor, T., Roebuck, M. C., & Donaldson, J. (2002). Changing the focus: The case for recognizing and treating marijuana use disorders. *Addiction*, *97*, S4-S15. Sartor, C.E., Lynskey, M.T., Bucholz, K.K., Madden, P.A.F., Martin, N.G., & Heath, A.C. (2009). Timing of first alcohol use and alcohol dependence: Evidence of common genetic influences. *Addiction*, *104*(9), 1512-1518.

[32] Dewit, D.J., Adlaf, E.M., Offord, D.R., & Ogborne, A.C. (2000). Age of first alcohol use: A risk factor for the development of alcohol disorders. *American Journal of Psychiatry*, *157*, 745-750. Kreichbaun, N., & Zering, G. (2000). Adolescent patients. In G. Zering (Ed.), *Handbook of alcoholism* (pp. 129-136). Boca Raton, LA: CRC Press.

[33] Arria, A. M., Dohey, M. A., Mezzich, A. C., Bukstein, O. G., & Van Thiel, D. H. (1995). Self-reported health problems and physical symptomatology in adolescent alcohol abusers. *Journal of Adolescent Health, 16*(3), 226-231. National Institute on Alcohol Abuse and Alcoholism. (2003). Underage drinking: A major public health challenge. *Alcohol Alert, 59,* 1-7. Sobell, M. B., Sobell, L. C., Cunningham, J. C., & Agrawal, S. (1998). Natural recovery over the lifespan. In E. L. Gomberg, A. M. Hegedus, & R. A. Zucker (Eds.), *Alcohol problems and aging* (NIAAA Research Monograph No. 33, pp. 397-405). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

[34] Gruber, E., DiClemente, R.J., Anderson, M.M., & Lodico, M. (1996). Early drinking onset and its association with alcohol use and problem behavior in late adolescence. *Preventative Medicine*., *25,* 293-300.

[35] Hingston, R. W., Heeren, T., Jananka., A., & Howland, J. (2000). Age of drinking onset and unintentional injury involvement after drinking. *Journal of the American Medical Association, 284,* 1527-1533.

[36] Hingston R. W., Heeren T., & Zakocs R. (2001). Age of drinking onset and involvement in physical fights after drinking. *Pediatrics, 108*(4), 872-877. Mrug, S., & Windle, M. (2009). Initiation of alcohol use in early adolescence: Links with exposure to community violence across time. *Addictive Behaviors*, *34,* 779-781.

[37] Kandel, D.B., Single, E., & Kessler, R. (1976). The epidemiology of drug use among New York State high school students: Distribution, trends, and changes in rates of use. *American Journal of Public Health*, *66*, 43-53. Keller, M., Lavori, P., Beardslee, W., Wunder, J., Drs., D., & Hasin, D. (1992). Clinical course and outcome of substance abuse disorders in adolescents. *Journal of Substance Abuse Treatment, 9,* 9-14. Kessler, R. C., Aguilar-Gaxiola, S., Berglund, P., Caraveo-Anduaga, J., DeWitt, D., Greenfield, S., Kolody, B., Offson, M., & Vega, W. (2001). Patterns and predictors of treatment seeking after onset of a substance use disorder. *Archives of General Psychiatry*, *58*(11), 1065-1071. Chen, J., & Millar, W. (1998). Age of smoking initiation: Implications for quitting. *Health Reports*, *9*(4), 39-46.

The risks associated with lowered age of onset are not ameliorated by social class or educational achievement and appear to be amplified in the transition between adolescence and young adulthood, e.g., 20.6% of full-time college students meet diagnostic criteria for an alcohol use disorder, and 7.9% meet criteria for a drug use disorder.[38]

Alcohol- and other drug-related problems rise throughout adolescence, peak at a 20% prevalence rate between ages 18-20, and progressively decline over subsequent decades.[39] In 2007, 133,742 adolescents were admitted to specialty sector addiction treatment in the United States, and a total of 464,323 youth under age 25 were admitted to such treatment.[40] In a recent analysis of 14,776 adolescent addiction treatment admissions, Dennis, White, and Ives[41] found the average age of first AOD use was 12.6 years, with 73% reporting onset of use between ages 10 and 14. This same review found that adolescents had used alcohol and other drugs an average of 3.2 years prior to their admission to treatment. Also noteworthy are studies concluding that certain patterns of adolescent AOD use (e.g., multiple drug use) are more resistant to positive forces of maturing out and are markers for potentially prolonged addiction and psychiatric careers, e.g., drug use disorders of adolescents and a drug use disorder co-occurring with an anxiety disorder or depression.[42]

From a historical perspective, the concept of recovery has greater applicability to adolescents and transition age youth today than at any time in American history. The concern is that most of what we know about recovery is derived from studies of adults. We know very little about the prevalence, pathways, processes, and stages of long-term recovery for adolescents with substance use disorders.[43] That paucity of understanding is reflected in acute care models of intervention into adolescent substance use disorders that lack sustained recovery support and that all too often leave adolescents and families feeling abandoned at discharge.[44] What is needed are long-term studies that illuminate how particular clinical and peer support interventions as well as particular developmental milestones in the transition into adulthood (e.g., leaving home, college, marriage or cohabitation, employment, parenthood) affect trajectories of resilience, addiction, and recovery among high-risk youth.[45]

---

[38] Wu, L., Pilowsky, D.J., Schlenger, W.E., & Hasin, D. (2007). Alcohol use disorders and the use of treatment services among college-age young adults. *Psychiatric Services*, *58*(2), 192-200.

[39] Dennis, M. L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

[40] SAMHSA (2008). National Survey on Drug Use and Health. Trends in Substance Use, Dependence or Abuse, and Treatment among Adolescents: 2002 to 2007. Office of Applied Studies, Substance Abuse and Mental Health Services Administration **(**SAMHSA**).**

[41] Dennis, M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer.

[42] Palmer, R.H.C., Young, S.E., Hopfer, C.J., Corley, R.P., Stallings, M.C., Crowley, T.J., & Hewitt, J.K. (2009). Developmental epidemiology of drug use and abuse in adolescence and young adulthood: Evidence of a generalized risk. *Drug and Alcohol Dependence*, *102*, 78-87.

[43] White, W., & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, *19*(2), 20-25.

[44] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration. *Blamed and Ashamed.* (2001). Alexandria, VA: Federation of Families for Children's Mental Health. White, W., Dennis, M., & Godley, M. (2002). Adolescent substance use disorders: From acute treatment to recovery management. *Reclaiming Children and Youth*, 11(3), 172-175.

[45] For a representative study, see D'Amico, E.J., Ramchand, R., & Miles, J.N.V. (2009). Seven years later: Developmental transitions and delinquent behavior for male adolescents who received long-term substance treatment. *Journal of Studies on Alcohol and Drugs*, *70*, 641-651.

Family Recovery

The concept of *family recovery* has significant applicability to children, adolescents, and transition age youth. Family recovery from the impact of a substance use disorder encompasses five dimensions:

- improvement of personal health and functioning of each family member,
- improvement in the quality of subsystem relationships (adult intimate relationships, parent child relationships, sibling relationships),
- increased clarity and consistency of family roles, rules, and rituals,
- enhanced quality and flexibility of external boundary transactions (the family's relationship with outside kinship and social networks), and
- reduction of risk for intergenerational transmission of AOD addiction and related problems.[46]

Addiction as a Family Disorder: Prolonged and excessive AOD use by a family member can impair family functioning and the personal development and global (physical, emotional, relational) health of individual family members.[47] The adverse effects of childhood exposure to parental addiction may be worse in families that remain intact than in families in which the child is abandoned by the alcoholic parent.[48] Children may also be negatively affected by exposure to sibling substance use, e.g., increased risk of early substance experimentation and subsequent problem development.[49] Same-generation family members (siblings, cousins) can constitute a risk for substance use or a protection against substance use based on their substance-related attitudes and behaviors.[50] This risk can be ameliorated by involving siblings in the treatment of their brother or sister.[51]

Childhood Risk and Resilience: Most children and adolescents rebound from the effects of an adverse childhood environment. Most (60-75%) children of alcohol-dependent parents will not go on to develop AOD problems,[52] but children who have experienced sustained exposure

---

[46] White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, *23*(4), 3-37; 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.

[47] Beardslee, W.R., Son, L., & Vaillant, G.E. (1986). Exposure to parental alcoholism during childhood and outcome in adulthood: A prospective longitudinal study. *British Journal of Psychiatry*, *149*, 584-591. Steinglass, P. (1993). *The alcoholic family*. Hutchinson Education.

[48] McCord, J. (1990). Long term perspectives on parental absence. In L.N. Robins, & M. Rutter (Eds.), *Long term perspective on parental absence* (pp. 116-134). Cambridge: Cambridge University Press.

[49] For a brief review see: Bamberg, J.H., Toumbourou, J.W., & Marks, B. (2008). Including siblings of youth substance abusers in a parent-focused intervention: Pilot test of the Best Plus Program. *Journal of Psychoactive Drugs*, *40*(3), 281-291.

[50] Waller, M.A., Okamoto, S.K., Miles, B.W., & Hurdle, D.E. (2003). Resiliency factors related to substance use/resistance: Perceptions of Native adolescents in the Southwest. *Journal of Sociology and Social Welfare*, *30*, 79-94. Brook, J.S., Whiteman, M., Gordon, A.S., & Brook, D.W. (1988). The role of older brothers in younger brothers' drug use viewed in the context of parent and peer influences. *Journal of Genetic Psychology*, *137*, 133-142.

[51] Bamberg, J.H., Toumbourou, J.W., & Marks, B. (2008). Including siblings of youth substance abusers in a parent-focused intervention: Pilot test of the Best Plus Program. *Journal of Psychoactive Drugs*, *40*(3), 281-291.

[52] Beardslee, W.R., Son, L., & Vaillant, G.E. (1986). Exposure to parental alcoholism during childhood and outcome in adulthood: A prospective longitudinal study. *British Journal of Psychiatry*, *149*, 584-591. Pandina, R.J., & Johnson, V. (1989). Familial drinking history as a predictor of alcohol and drug consumption among adolescent children. *Journal of Studies on Alcohol*, *50*, 245-254.

to severe parental addiction and/or mental illness can suffer profound developmental effects and are in greatest need of indicated prevention and early intervention services.[53]

- There is a clear but complex relationship between parental addiction, neglect, and maltreatment of children and the subsequent emotional and behavioral health of children.[54]
- Children, particularly male children, of alcohol/drug-dependent parents are at increased risk of developing these same problems as well as other developmental problems.[55]
- Children of alcohol dependent parents have 4-10 times the risk of experiencing an alcohol use disorder in their lifetimes compared to children without these genetic/environmental risk factors.[56]
- The mechanisms driving risk for intergenerational transmission of AOD problems include biological/genetic vulnerabilities, parental modeling, child/family distress, inadequate conveyance of coping skills, positive alcohol expectancies (particularly for males), and increased environmental availability of AOD.[57]
- Children of alcohol/drug dependent parents are also at risk for "indirect recurrence" via a process of "assortative mating" through which they select intimate partners who have or are likely to develop AOD problems.[58]

---

[53] Werner, E.E. (2004). Journeys from childhood to midlife: Risk, resiliency and recovery. *Pediatrics*, *114*(2), 492.

[54] Blau, G.M., Whewell, M.C., Gullotta, T.P., & Bloom, M. (1994). The prevention and treatment of child abuse in households of substance abusers: A research demonstration progress report. *Child Welfare*, *73*(1), 83-94. White, W., Woll, P., & Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[55] Bennett, L.A., Wolin, S.J., Reiss, D., & Teitelbaum, M.A. (1987). Couples at risk for transmission of alcoholism: protective influences. *Family Process*, *26*, 111-129. Goodwin, D.W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books. Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M., Fenton, B., Zhang, H., O'Malley, S., & Rounsaville, B.J., (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, *55*, 973-979. Russell, M. (1990). Prevalence of alcoholism among children of alcoholics. In M. Windle, & J.S. Searles (Eds). *Children of alcoholics: Critical perspectives* (pp. 9-38), New York: Guildford Press. Schuckit. M.A. (2009). An overview of genetic influences in alcoholism. *Journal of Substance Abuse Treatment*, *36*(Suppl), S5-S-14.

[56] Enoch, M. (2006). Genetic and environmental influences on the development of alcoholism. *Annals of the New York Academy of Science*, *1094*, 193-201. Goodwin, D.W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books. Russell, M. (1990). Prevalence of alcoholism among children of alcoholics. In M. Windle, & J.S. Searles (Eds). *Children of alcoholics: Critical perspectives* (pp. 9-38), New York: Guildford Press. Sher, K.J. (1993). Children of alcoholics and the intergenerational transmission of alcoholism: A biopsychosocial perspective. In J.S.. Baer, G.A. Marlatt, & R.J. McMahon (Eds), *Addictive behavior across the life span* (p. 3-33), Newbury Park: Sage Publications. Vitaro, F., Dobkin, P.L., Carbonneau, R. & Tremblay, R.E. (1996). Personal and familial characteristics of resilient sons of alcoholics. *Addiction*, 91(8), 1161-1177.

[57] Handley, E., & Chassin, L. (2009). Intergenerational transmission of alcohol expectancies in a high-risk sample. *Addictive Behaviors*, *70*, 675-682.

[58] Bennett, L.A., Wolin, S.J., Reiss, D., & Teitelbaum, M.A. (1987). Couples at risk for transmission of alcoholism: protective influences. *Family Process*, *26*, 111-129. Grant, J.D., Heath, A.C., Bucholz, K.K., & Madden, P.A. (2007). Spousal concordance for alcohol dependence : Evidence for assortative mating or spousal interaction effects? *Alcoholism: Clinical and Experimental Research, 31*(5), 717-728. Hall, R.L, Hesselbrock, V.M., & Stabenau, J.R. (1983). Familial distribution of alcohol use: II. Assortative mating of alcoholic probands, *Behavior Genetics, 13*(4), 373-382. Olmsted, M.E., Crowell, J.A., & Waters, E (2003). Assortative mating among adult children of alcoholics and alcoholics. *Family Relations*, *52*(1), 64-71.

Parental Recovery and Child Development: Key aspects of family life disrupted by addiction continue to be disrupted during the early years of recovery.[59] For example, child maltreatment by an addicted parent recedes in tandem with recovery initiation, but development or re-establishment of a healthy parent-child relationship can be a prolonged process.[60] Recovery initiation, by suddenly destabilizing family roles, rules, rituals, and relationships, exerts strain on family members and the family system as a whole. Such strain can result in emotional/behavioral problems in children, pose threats to adult intimate relationships, and threaten family stability.[61] Support provided to a family through the transition from active addiction to stable recovery can enhance the development and emotional health of children in the family.[62] Family- and couples-focused treatment generates improved child adjustment outcomes superior to those found in treatments that focus solely on the individual with the substance use disorder.[63]

"Alcohol abuse has pervasive [negative] effects on spouses and children, but these effects diminish or even disappear entirely when the alcoholic family member is recovering."[64] Multiple studies confirm the improved health of the children of a substance-dependent parent who enters and sustains a recovery process.[65] The chain of influence behind such improvement seems to be professional treatment, which increases AA or other mutual aid attendance, which enhances abstinence rates, which in turn generate improvements in the behavioral health of the children of those treated.[66] These effects are present even when children are not directly involved in family/child-oriented treatment processes.

There are a growing number of interventions designed to enhance protective/resiliency factors in children exposed to AOD problems within their families that could be integrated into mainstream addiction treatment.[67] Some treatment programs, such as the Betty Ford Center,

---

[59] Brown, S. (1994). What is the family recovery process? *The Addiction Letter*, *10*(10), 1, 4. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

[60] White, W., Woll, P., & Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[61] Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

[62] Brown, S. (1994). What is the family recovery process? *The Addiction Letter*, *10*(10), 1, 4. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

[63] Powers, M.B., Vedel, E., & Emmelkamp, P.M.G. (2008). Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. *Clinical Psychology Review*, *28*(6), 952-962.

[64] Moos, R.H., Finney, J.W. & Cronkite, R.C (1990). *Alcoholism Treatment: Context, process and outcome.* Oxford University Press; O'Farrell, T.J., & Feehan, M. (1999). Alcoholism treatment and the family: Do family and individual treatments for alcoholic adults have preventative effects for children. *Journal of Studies on Alcohol*, *Supplement 13*, 125-129.

[65] Burdzovic, A.J, O'Farrell, T. J., & Fals-Stewart, W. (2006). Does individual treatment for alcoholic fathers benefit their children? A longitudinal assessment. *Journal of Consulting and Clinical Psychology, 74*, 191–198; Callan, V.J., & Jackson, D. (1986). Children of alcoholic fathers and recovered fathers: Personal and family functioning. *Journal of Studies on Alcohol*, *47*, 180-182. Kelley, M.L., & Fals-Stewart, W. (2002). Couples- versus individual-based therapy for alcohol and drug abuse: Effects on children's psychosocial functioning. *Journal of Consulting and Clinical Psychology*, *70*, 417-427. Moos, R.H., & Billings, A.G. (1982). Children of alcoholics during the recovery process: Alcoholics and matched control families. *Addictive Behaviors*, *7*, 155-163.

[66] Burdzovic Andreas, J.B., & O'Farrell, T.J. (2009). Alcoholics Anonymous attendance following 12-step treatment participation as a link between alcohol-dependent fathers' treatment involvement and their children's externalizing behaviors. *Journal of Substance Abuse Treatment*, *36*, 87-100.

[67] Finkelstein, N., Rechberger, E., Russell, L.A., VanDeMark, N.R., Noether, C.D., O'Keefe, M., Gould, K., Mockus, S., & Rael, M.V. (2005). Building resilience in children of mothers who have co-occurring disorders and histories of violence. *The Journal of Behavioral Health Services and Research*. *32*(2), 141-154.

have invested considerable resources in developing a child-focused service and support track for the children of parents treated at the Center.

There is a rapidly accumulating body of scientific evidence that addiction and recovery each exert a profound influence on the family in general and on children in particular. In spite of this evidence, services provided by the mainstream addiction treatment system for those affected by severe AOD problems range from non-existent, to "reactive, poorly thought out and marginal,"[68] to exemplary models that have yet to be widely replicated. It remains to be seen whether defining the roles of family and children within recovery-oriented systems of care will alter this bleak appraisal.

Recovery of Adolescents and Transition Age Youth

Discussing recovery in the context of adolescent and young adult substance use disorders rests on several critical points.

Problem Prevalence and Help-Seeking: In 2007, 317,279 adolescents (under the age of 18) and 330,581 transition age youth (18-24) were admitted for specialized addiction treatment in the United States.[69] 7.9% of youth aged 12-17 met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one tenth (7.6%) of those youth received specialized addiction treatment in the past year.[70] More than one fifth (21.1%) of transition age youth (aged 18-25) met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one tenth (7%) received specialized addiction treatment in the past year.[71] The profile of transition age youth most in need of treatment is that of a young adult male with a family income of less than $20,000 or more than $75,000 who does not perceive himself as needing treatment.[72]

Specialized Resources for Adolescent Treatment and Recovery: Treatment and recovery support resources for adolescents have grown explosively in the past three decades.[73] The SAMHSA-sponsored 2000 National Survey of Substance Abuse Treatment Services[74] provided a window into the rapidly growing network of adolescent treatment programs in the United States. Of the 13,428 addiction treatment programs that participated in the survey, 4,969 provided services to adolescents. Adolescent treatment services were provided by 37% of private non-profit facilities, 36% of private for-profit facilities, 34% of state-operated facilities, and 65% of tribal owned facilities.[75]

There is also a growing network of young peoples' recovery support meetings and internet-based social networking/support sites for youth[76] as well as newly developed, assertive

---

[68] Copella. A., & Orford, J. (2002). Addiction and the family: Is it time for services to take notice of the evidence. *Addiction*, *97*, 1361-1363.

[69] SAMHSA/OAS 2009, Personal communication with Dr. James Collier.

[70] SAMHSA/OAS 2009 Personal communication with Dr. James Collier.

[71] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 25, 2009). *The NSDUH Report: Young adults' need for and receipt of alcohol and illicit drug use treatment, 2007*. Rockville, MD: Author.

[72] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 25, 2009). *The NSDUH Report: Young adults' need for and receipt of alcohol and illicit drug use treatment, 2007*. Rockville, MD: Author.

[73] White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor, 3*(2), 20-23.

[74] Office of Applied Studies (OAS) (2000). *Substance Abuse and Mehtanl Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), October, 2000*.

[75] Office of Applied Studies (OAS) (2000). Substance Abuse and Mehtanl Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), October, 2000.

[76] Passetti, L., & White, W. (2008). Recovery meetings for youth. *Journal of Groups in Addiction and Recovery, 2*, 97-121.

procedures aimed at enhancing linkage, engagement, and ongoing participation in such groups.[77]

Adolescent Treatment and Recovery Outcomes: A recent review[78] of adolescent treatment outcome research drew several important conclusions, including the following:

1. Many adolescents mature out of substance-related problems in the transition into adult role responsibilities; for other adolescents, substance-related problems evolve into a chronic, debilitating disorder.
2. Adolescents who mature out of substance-related problems often do so without conceptualizing these problems and their resolution within an addiction/recovery framework.
3. Factors that increase risk and inhibit maturing out include a family history of AOD problems, early age of initiation of regular use, co-occurring emotional/behavioral problems, and a low level of positive family and peer support.
4. The earlier the intervention (in terms of both age and months/years of use), the better the long-term recovery outcomes.
5. There are evidence-based, brief therapies that are effective for many substance-involved adolescents.
6. Viewed as a whole, 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.
7. All treatment programs are not the same: programs with the best clinical outcomes: a) treat a larger number of adolescents, b) have a larger budget, c) use evidence-based therapies, d) offer specialized educational, vocational, and psychiatric services, e) employ counselors with two or more years experience working with adolescents, f) offer a larger menu of youth-specific services (e.g., art therapy, recreational services), and g) are perceived by clients as empathic allies in the long-term recovery process.
8. Most adolescents are precariously balanced between recovery and relapse in the months following addiction treatment.[79] The period of greatest vulnerability for relapse is in the first 30 days following treatment; adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment.
9. Recovery stability is enhanced by post-treatment monitoring and periodic recovery checkups.[80]
10. The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome. Adolescents who experience major relapse have the highest density of substance users in their post-treatment social milieu.

---

[77] 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.

[78] Risberg, R., & White, W. (2003) Adolescent substance abuse treatment: Expectations versus outcomes. *Student Assistance Journal, 15*(2), 16-20.

[79] 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.

[80] 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.

11. The post-treatment home environment also plays a significant role in recovery/relapse outcomes.
12. Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates, and their effect is dependent upon intensity and duration of participation.

The Phenomenology of Adolescent Recovery: The concept of recovery seems to be a viable one for adolescents seeking to reconstruct their lives following significant and sustained AOD-related problems.[81]

Conceptual Frameworks for Organizing Child and Adolescent Services

There are multiple concepts that have served or could serve as an organizing framework for the design of child and adolescent (C & A) services.

System of Care: The concept of "system of care" has provided an organizing framework for the modern reform of children's mental health services.[82] System of care values and principles grew out of the recognition that the prevailing model of mental health care for children suffered serious problems related to attraction and accessibility, restrictiveness, and isolation from other youth and family services. There was also concern that prevailing models of care suffered from paternalism (failure to involve youth in decisions related to their own care), family exclusion (blame rather than invitation for service participation), and a lack of understanding about cultural differences across youth and families being served. What emerged was a vision of a youth/family-focused, comprehensive, coordinated, and community-based "system of care" for children and families needing mental health care and new planning frameworks (e.g., "wraparound" approaches) to create such a system of care.[83]

In April 2003, the CSAT Strengthening Communities for Youth Performance Monitoring Work Group identified nine "system of care" principles that should be applied to the design of treatment for adolescent substance use disorders. The Work Group concluded that such care should be:

- family and youth focused,
- culturally competent,
- partnership (interagency/intra-agency) guided,
- coordinated/collaborative,
- community-based,
- accessible/no wrong door,
- individualized,
- clinically competent, and
- accountable.[84]

[81] Long, W., & Vaughn, C. (1999). "I've had too much done to my hear"" The dilemma of addiction and recovery as seen through seven youngsters' lives. *Journal of Drug Education*, *29*(4), 309-322.

[82] Stroul, B., & Friedman, R. (1996). The system of care concept and philosophy. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 1-22). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

[83] Stroul, B. (2002). *Issue brief—System of care: A framework for system reform in children's mental health*. Washington D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

[84] Modified from CMHS system of care principles on April 3-4, 2003

Positive youth development (PYD) is a strategy for developing personal (physical, emotional, cognitive, social, and moral) competence in all children and adolescents.[85]

> *When using the PYD approach, workers focus on youth assets rather than deficits, collaborate with youth in planning the youth's future, build youth competencies rather than doing tasks for the youth, adopt a holistic perspective of healthy personal growth, and engage in long-range planning rather than short-term solutions*.[86]

PYD is asset-based, collaborative, community-oriented, competence-building, connected (relationship focused), culturally nuanced, holistic, long-range, normative (emphasis on shared similarities with other youth), promotive (focused on pro-social activity), and universal (aimed at all youth).[87] While PYD shares much in common with the resiliency and recovery concepts, PYD is distinguished from resilience and recovery by the PYD focus on the entire universe of children and adolescents rather than just those at high risk or who are already experiencing problems.

Resilience "is the ability of individuals to remain healthy even in the presence of risk factors."[88] It can be thought of as protective shields existing at multiple levels of the ecosystem or as relational processes across these levels that bestow varying levels of immunity in the face of risk exposure.

Definitions of resilience widely differ. Some define resilience as a protective shield of traits that neutralize risk factors to yield a state of *invulnerability* or *extreme hardiness.* Others define resilience as the ability to rebound from toxic influences and traumatic experience. Some of the latter definitions use resilience and recovery interchangeably or link the two conditions.

There is growing consensus that resilience exists only in the context of adversity. Resilience is not a euphemism for health/wellness, social competence, or academic/vocational functioning—conditions often achieved in the absence of adversity. Resilience instead refers specifically to positive developmental outcomes in spite of personal and environmental risk factors.[89] Whereas the focus of PYD is on all children, resilience applies to the ability of risk-exposed children and adolescents to avoid developing problems related to those risk factors. Resilience does not apply to all children, only those exposed to risk. Put simply, without risk, there is no resilience.[90]

Resilience has been an important concept in the context of child services because it helped the field move from a "discourse of psychopathology and failure" to a discourse of potential.[91] Resilience is a valuable term applied to developmental problems of children and adolescents because it affirms a naturally positive momentum for human development. The fact is, most children experiencing childhood distress will not experience prolonged effects from such

---

[85] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[86] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[87] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[88] *Risk and resilience 101* (2004). National Center for Mental Health Promotion and Youth Violence Prevention. Retrieved July 30, 2009 from http://www.promoteprevent.org.

[89] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[90] Meschke, L.L., & Patterson, J.M. (2003). Resilience as a theoretical basis for substance abuse prevention. *Journal of Primary Prevention, 23*, 483-514. Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

[91] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

distress or will have recovered from such problems when re-evaluated at mid-life.[92] The resilience concept also brings a clear identification of risk and protective factors, optimism related to long-term developmental outcomes in spite of personal adversity, and the importance of high expectations, care and support, and meaningful participation within service organizations and the larger life of the community.[93]

The research on protective factors is particularly important for the design of children's services. Studies of children at risk for the development of AOD problems who did not develop such problems reveal a variety of protective shields. Theokas and Lerner[94] have conceptualized these shields in terms of personal assets (social conscience, personal values, interpersonal values and skills, risk avoidance, activity participation, positive identity, and school engagement) and ecological assets (connection to family, adult mentors, connection to community, parent involvement, connection to school, rules and boundaries, and safety) that can enhance resiliency and positive development of youth.

Trait-based protective factors include:

- cognitive skills (intelligence, attention, problem solving),[95]
- "easy temperament, a low level of emotional reactivity, and a normal level of novelty-seeking,"[96]
- social orientation (desire for and capacity to enjoy social interaction), sociability, and sustained social relationships,
- self-confidence and optimism about one's future,[97]
- pro-social values and beliefs, and
- spiritual/religious orientation.[98]

The family environment can also include protective factors that reduce risk of AOD problem development in children of an alcohol-dependent parent. These factors include:

- positive relationship with the non-alcoholic parent,[99]
- close supervision of children by the non-alcoholic parent,[100]

---

[92] Werner, E.E. (2004). Journeys from childhood to midlife: Risk, resiliency and recovery. *Pediatrics*, *114*(2), 492.

[93] Bernard, B. (2004). *Resilience: What we have learned*. San Francisco, WestEd.

[94] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30.

[95] Luthar, S.S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Plenum.

[96] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[97] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[98] Langehough, S.O., Walterns, C., Knox, D., & Rowley, M. (1997). *Spirituality & Religiosity as factors in adolescents' risk for anti-social behaviors and use of resilient behaviors*. Paper presented at the annual Conference of the NCFR Fatherhood and Motherhood in a Diverse and Changing World Conference, Arlington, VA.

[99] Reich, W., Earls, F., Frankel, O., & Powell, J.J. (1988). A comparison of the home and social environments of children and alcoholic and non-alcoholic parents. *British Journal of Addiction*, *83*, 831-839.

[100] Vitaro, F., Dobkin, P.L., & Zoccolillo, M. (1996). Personal and familial characteristics of resilient sons of male alcoholics. *Addiction*, *91*, 1161-1177.

- quality relationship with both parents,[101]
- maintenance of key family rituals, e.g., family celebrations (birthdays, holidays), family traditions (vacations, reunions), and patterned routines (meals, bedtimes),[102] and
- access to social support outside the family.[103]

Finally, there are community protective factors that reduce the risk of developing AOD-related problems. Luthar[104] lists four such factors:

- access to quality education,
- participation in social/athletic activities supervised by adults,
- safe and cohesive neighborhoods, and
- access to health and social services.

Mershke and Patterson[105] reviewed the research on protective factors and drew the following conclusions:

- Protective factors are not static; they advance, are maintained, or recede as each layer of the ecosystem evolves.
- Protective factors are most important during windows of vulnerability, e.g., transition from childhood to adolescence.
- Protective factors are to resilience what recovery capital is to the long-term resolution of AOD problems.
- Protective factors increase in potency and duration of effects when combined.

Resistance has two potential meanings relevant to the current discussion: 1) an innate hardiness that allows one to be exposed to an infectious agent without becoming ill, and 2) the act of desisting or ceasing AOD use as an act of cultural or political survival.[106] The former views resistance as synonymous with resilience; the latter views abstinence as an act of personal and cultural survival in response to the perceived use of alcohol and other drugs as tools of social oppression or as a toxic balm used to ease the pain of such oppression. Resistance in this latter view is seen as critical to the process of personal, cultural, and political awakening of historically disempowered peoples. In such contexts, healing the individual, family, and community are

[101] Kuntsche, E., Van Der Vorst, H., & Engels, R. (2009). The earlier the more? Differences in the links between age at first drink and adolescent alcohol use and related problems according to quality of parent-child relationship. *Journal of Study of Alcohol and Drugs*, *70*, 346-354.

[102] Bennett, L.A., Wolin, S.J., & Reiss (1988). Cognitive behavioral and emotional problems among school-age children of alcoholic parents. *American Journal of Psychiatry*, *145*, 185-190. Wolin, S.J., Bennet, L.A., Noonan, D.L., & Teitelbaum, M.A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol*, *41*, 199-214.

[103] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[104] Luthar, S.S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Plenum.

[105] Meschke, L.L., & Patterson, J.M. (2003). Resilience as a theoretical basis for substance abuse prevention. *Journal of Primary Prevention*, *23*, 483-514.

[106] Dan D. (2008). *Resilience thinking and recovery management: Notes toward an ecological model of system transformation*. Unpublished Manuscript. Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

viewed as inseparable and require action at all of those levels.[107] Whereas resilience emphasizes latent strengths and capacities, resistance emphasizes the importance of individual and collective *consciousness* and *action.* The concept of resistance has particular salience within historically disempowered communities.[108]

Recovery from a substance use disorder has been recently defined in terms of three critical ingredients: sobriety, global health (physical, cognitive, emotional, relational, spiritual), and citizenship.[109] The term *recovery* as traditionally used applies only to those with a pre-existing disorder (there must be something to recover from) and those who meet key criteria of personal volition and durability (recovery must be voluntary and extended—measured across time via categories of early, sustained, and stable recovery). Pathways (secular, spiritual, religious) and personal styles of recovery initiation and maintenance vary considerably across individuals and cultures.[110] The concepts of *family recovery* and *community recovery* have also been applied to families and communities who repair and transcend the adverse systemic effects of severe and prolonged AOD problems.[111]

What has not been fully explored is the application of the recovery concept to youth. Because the recovery concept was developed out of a base of adult experience, its meanings and utility become less clear as one moves its application from transition age youth to adolescents to children. Even the basic dimensions of recovery must be defined in the context of youth development. For example,

- Do adolescents transitioning into adulthood who resolve severe AOD problems by decelerating AOD use to subclinical levels rather than stopping AOD use meet the "sobriety" definition of recovery? How would a "recovery-oriented" model of care view such patterns of problem resolution?
- How does the measurement of global health differ for youth than for adults? How can key developmental tasks of childhood, adolescence, and transitioning into adulthood be integrated in the "global health" component of recovery?
- How does the concept of citizenship apply to children and adolescents? What behaviors would distinguish the achievement of this dimension of recovery for children and adolescents?

Such questions have yet to be fully answered.

Recovery Management and Recovery-Oriented Systems of Care

Recovery management is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery

---

[107] *The Red Road to Wellbriety* (2002). Colorado Springs, CO: White Bison, Inc.

[108] White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[109] Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. Laudet, A.B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

[110] White, W., & Kurtz, E. (2006). The varieties of recovery experience. International Journal of Self Help and Self Care, *3*(1-2), 21-61. White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[111] White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor, 8*(5), 34-38.

maintenance, and the quality of personal/family life in long-term recovery.[112] *Recovery-oriented systems of care* (ROSC) encompass the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families affected by AOD problems and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in this phrase is not a federal, state, or local agency, but a macro level organization of the larger cultural and community environment in which long-term recovery is nested.[113] *Systems transformation* involves planned efforts to align service concepts, service practices, and service contexts (e.g., community attitudes, funding, and regulatory policies) to support long-term addiction recovery for individuals, families, neighborhoods, and communities. ROSC rest on key principles or understandings about recovery (See Table 3) and contain key defining characteristics (See Table 4).

Table 3: Recovery-Oriented Systems of Care: Guiding Principles

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-definition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

Source: CSAT National Summit on Recovery, September 28-29, 2007[114]

Table 4: Characteristics of a Recovery-Oriented System of Care

1. Person-centered
2. Family and other ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care
6. Partnership-consultant relationships
7. Strength-based
8. Culturally responsive
9. Responsiveness to personal belief systems
10. Commitment to peer recovery support services

[112] 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.

[113] White, Ibid.

[114] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

11. Inclusion of the voices and experiences of recovering individuals and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and outreach
15. Outcomes driven
16. Research-based
17. Adequately and flexibly financed

Source: CSAT National Summit on Recovery, September 28-29, 2007[115]

CSAT's 2007 National Summit on Recovery was followed by a 2008 "Consultative Session to Design a Recovery-Oriented System of Care for Adolescents and Transition Age Youth with Substance Use Disorders or Co-Occurring Mental Health Disorders." Table 5 summarizes how participants of this meeting defined the critical characteristics of an ROSC for youth.

Table 5: Characteristics of a Recovery-Oriented System of Care for Youth

1. Family-focused/family driven
2. Age appropriate/developmental approach
3. Promotes resilience
4. Empowers youth
5. Acknowledges non-linear nature of recovery
6. Strengths-based
7. Addresses recovery capital
8. Individualized
9. Promotes hope
10. Broad array of services and supports
11. Culturally competent
12. Accessible
13. Provides choices
14. Promotes personal responsibility
15. Integrated
16. Ecological/systems perspective
17. Continuity of care
18. Engaging
19. Non-discriminatory
20. Collaborative
21. Cost-effective
22. Authenticity (honesty, integrity, fun, respect, trust, tolerance, patience)
23. Evidence-based
24. Focuses on quality of life
25. Flexible
26. Promotes accountability (outcomes)
27. Realistic
28. Statewide-level of organization

[115] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Source: Cavanaugh, Goldman, Le, & Bender, 2008[116]

Three things are striking in the comparison of Tables 3 and 4 with Table 5. First, the definition of core elements of an ROSC for adults and youth share many if not most common elements, e.g., emphasis on individualized care, family involvement, personal/family strengths, continuity of care, cultural competence, and accountability of outcomes. Second, stakeholders who defined the ideal ROSC for youth placed greater emphasis on developmentally appropriate services, resilience, empowerment/choice, and access/engagement. Third, in spite of the general call for more developmentally appropriate services in Table 5 and in the larger literature on the application of ROSC to youth, there is a striking lack of detail about what this means. There is not a clear delineation of the role of peer-based recovery support services within a youth-focused ROSC nor guidance on how to maintain peer supports over time (via peer leadership development initiatives) and how to avoid any potential iatrogenic effects of peer-based interventions. Also lacking is a clear definition of the meaning of family-focused youth services, e.g., how the developmental task of emancipation from family can be balanced with the need for sustained family support for recovery, or how concepts like empowerment and choice will be applied to children and adolescents. There is much work to be done to define a youth-focused ROSC at the level of service practice design.

Shared Characteristics of Organizing Concepts

Whereas the concepts of system of care and positive youth development were developed specifically to address concerns related to services for children and adolescents, resilience and recovery have historically been drawn from adult experience and then applied, often without adaptation, to children and adolescents. In spite of their varied pedigrees, there is considerable overlap between all of these concepts. For example, the key elements of system of care and positive youth development have much in common with the key elements being defined as crucial to a recovery-oriented system of care.[117]

While resilience and recovery are often thought of as separate phenomenon, at least some investigators have suggested that recovery may actually be a manifestation of resilience that occurs after exposure to the adversity of addiction. This suggests the need to define resilience with a life-span trajectory and to consider the possibility that recovery may be a manifestation of a delayed form of resilience activated by some developmental turning point.[118] Resilience (in the face of extremely adverse experience) and recovery similarly share overlapping strategies: achieving both states involves identity reconstruction (who was I, what happened, who am I now—or who am I becoming), assertive approaches to emotional self-management, and forging a healthy social support network.[119]

---

[116] Cavanaugh. D., Goldman, S., Le, L., & Bender, C. (2008b). *Consultative session to design a recovery-oriented system of care for adolescents and transition age youth with substance use disorders or co-occurring mental health disorders*. CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[117] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

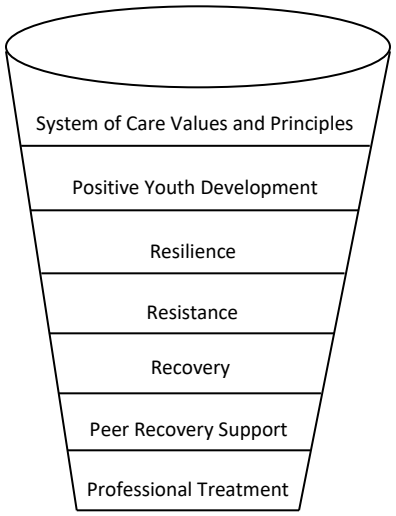
[118] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[119] Millar. G.M., & Stermac, L. (2000). Substance abuse and child maltreatment: Conceptualizing the recovery process. *Journal of Substance Abuse Treatment*, *19*(2), 175-182.

Those who have studied recovery and resilience refer to a level of extraordinary functioning that can emerge not in spite of past risk factors but because of one's experience of having transcended such risks. White and Kurtz[120] refer to an "enriched state of recovery"—a depth of meaning and purpose, a level of functioning, and a style of service to others far superior to their pre-addiction state. Such amplified recovery occurs as an unexpected fruit of recovery for some individuals/families. This finding parallels Calhoun and Tedeschi's[121] findings that some individuals experience profoundly positive changes in the aftermath of traumatic distress. These changes include an expanded vision of life opportunities, deepening of intimate and social relationships, strengthening of personal character and coping abilities, a refocusing of priorities, and heightened experience of spirituality.[122] Rutter[123] has also explored the "steeling effect" in which experiencing adversity at one stage of life strengthens resistance to such distress at another level of life—a phenomenon suggested by the phrase "stronger at the broken places." This is analogous to people achieving heightened immunity following exposure to an infectious agent.

Rather than think of recovery and resilience in either/or terms, it may be helpful to think of systems transformation guided by both resilience and recovery. Child and family advocates in many places have embraced these concepts as complementary.[124] Figure 1 illustrates how these concepts might be viewed as linked with a total system of care and support.

Figure 1: Organizing Concepts for AOD-Related Services for Children and Adolescents



Whichever concepts are embraced, the field of children's services appears committed to casting aside pathologizing concepts and language that focus attention on "disorder and disease" and

[120] White, W., & Kurtz, E. (2006). The varieties of recovery experience. International Journal of Self Help and Self Care, *3*(1-2), 21-61.

[121] Calhoun, L.G., & Tedeschi, R.G.. Eds. (2006). *Handbook of post-traumatic growth: Research and practice*. Mahwah, NJ: Erlbaum.

[122] Neimeyer, R.A. Ed. (2001). *Meaning reconstruction and the experience of loss.* Washington D.C.: American Psychological Association.

[123] Rutter, M (1981) Maternal Deprivation Reassessed, Second edition, Harmondsworth, Penguin.

[124] Walker, J.S., & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

embracing new concepts and language focused on "hoping and coping."[125] The field also appears poised to reject models that define problems, resilience, and recovery as exclusively intrapersonal processes. The future lies in a focus on the ecology of resilience and recovery—placing these experiences and service strategies derived from them in their family, community, and cultural contexts.[126]

Primary Prevention, Early Intervention, Treatment, and Recovery Support

Discussions of the applicability of the recovery and resiliency concepts to children's services lead to questions about where prevention and early intervention fit into an ROSC. Prevention programs can be divided into universal approaches (targeting the general population), selective approaches (targeting groups at high risk for subsequent AOD problems), and indicated approaches targeting individuals already exhibiting the emotional/behavioral precursors associated with later AOD problems.[127] Given that 1) children of parents with a history of substance use disorders are among those at highest risk for developing such disorders, 2) the recovery of the parent increases the child's resistance to and potential recovery from a substance use disorder, and 3) at risk children of parents in treatment can be identified and targeted for prevention and early intervention strategies, there is a clear link between addiction treatment and recovery support for the parent and strategies of prevention and early intervention with their at risk or substance-using children. Put simply, addiction treatment and recovery support services for parents constitute a strategy of prevention for their children. These strategies can be further amplified by involving children in the treatment of their parent and by providing specialized services designed to enhance the child's recovery from the developmental insults of parental addiction and to enhance the child's future resilience and resistance related to AOD-related problems.

The pool of people currently experiencing substance use disorders is not static, but a dynamic ever-changing population. Entry into this pool progressively draws from five groups:

1. individuals in recovery from AOD problems who remain at risk for returning to AOD use and its concomitant problems,
2. AOD consumers who are experiencing subclinical problems (not yet meeting diagnostic criteria for a substance use disorder) related to their AOD use,
3. heavy consumers of AOD as measured by frequency and quantity of use,
4. episodic and moderate but at risk AOD consumers, and
5. children, adolescents, and adults who have not yet used AOD but who are at high risk for the development of AOD problems.

Recovery-oriented systems of care must respond not just to those in acute crisis and those who need recovery maintenance support. The ideal ROSC seeks to shrink the size of all of the above populations via effective strategies of prevention and early intervention. ROSC, with its larger focus on promoting recovery-friendly communities, actually elevates the value and importance of such strategies. As an example, one could easily take the position based on the data

[125] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

[126] Waller, M.A., Okamoto, S.K., Miles, B.W., & Hurdle, D.E. (2003). Resiliency factors related to substance use/resistance: Perceptions of Native adolescents in the Southwest. *Journal of Sociology and Social Welfare*, *30*, 79-94.

[127] Gordon, R. (1987). An operation classification of disease prevention. In J.A. Steinberg, & M.M. Silberman (Eds.), *Preventing mental disorders: A research perspective* (DHHS Pub. No. (ADM) 87-1492). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health.

presented in this paper that the treatment of every adult parent should include child-focused prevention and early intervention services aimed at breaking the intergenerational transmission of AOD-related problems.

Recovery Concept and Children: Advocates

Several major arguments have been set forth advocating the "added value" the recovery concept brings to service design efforts for children, adolescents, and transition age youth. These proposed advantages include the following:

- Recovery as an organizing concept helps shift attention from diagnosis and clinical treatment of children toward a more holistic, developmental perspective.[128]
- Recovery helps shift the focus of children's services from that of pathology, deficit inventories, and doomed prognoses to a focus on hope/optimism for each child's long-term positive development and the achievement of a meaningful and purposeful life.[129]
- Recovery adds the needed dimensions of wellness (wholeness) and spirituality—the idea that there are previously hidden powers within and outside the self that can be mobilized to promote healing, wellness, and quality of life.[130]
- Recovery emphasizes the importance of empowerment and choice.[131]
- Recovery adds new emphasis on the power of personal identity as an agent of prevention and healing: story construction/reconstruction, storytelling, and story listening.[132]
- Recovery contains the potential to move beyond symptom reduction to the potential to thrive: transcending illness/trauma in ways that render one a better person and bestow a fuller and more meaningful life than existed before,[133] e.g., recovery offering new

[128] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30.

[129] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8. Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies*, *15*, 525-527. Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4. White, W.L., Laudet, A.B., & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional, 4*(4), 18-23.

[130] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22.

[131] Langehough, S.O., Walterns, C., Knox, D., & Rowley, M. (1997). *Spirituality and Religiosity as factors in adolescents' risk for anti-social behaviors and use of resilient behaviors.* Paper presented at the annual Conference of the NCFR Fatherhood and Motherhood in a Diverse and Changing World Conference, Arlington, VA. Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22; 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

[132] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22; White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, MN: Hazelden.

[133] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22. White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

competencies, unexpected opportunities, deeper relationships, greater compassion, reordered personal priorities, and deepened spirituality.[134]

- The recovery concept is very congruent with the *positive youth development* (PYD) movement and "system of care" values and principles that have guided the design of child services since the 1980s.[135]
- The idea of "parallel process" within the ROSC literature acknowledges systems failures within the professional treatment of adolescent substance use and mental health disorders and the need for a recovery process for systems of care as well as individuals and families.[136]
- Recovery as an organizing concept brings needed elements not traditionally included in child and adolescent services, e.g., understandings of historical trauma and social stigma and the emphasis on treating/healing the environment.[137]
- The recovery management model promises needed continuity of support over time to the child/family and offers an alternative to the sense of abandonment that often accompanies acute care models of adolescent intervention,[138] but care must be taken not to indiscriminately apply a "chronic care" model to adolescents—many of whom will experience acute, transient AOD problems. Such misapplication could have significant iatrogenic (harm in the name of help) effects.[139]
- Integrating the ideas of recovery and resilience "draws attention to the importance of connectedness as a developmental asset for all youth."[140]
- Using recovery as an organizing concept for children's services provides impetus for the involvement of primary care physicians in the assessment and early intervention into child and adolescent AOD problems.[141]
- The focus on the role contextual factors play in the development and resolution of adolescent substance use disorders (e.g, the influence of AOD availability, AOD peer group norms, AOD-related laws and institutional policies, alcohol advertising,

---

[134] Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process*, *46*(2), 207-227.

[135] Eccles, J.S., & Gootman, J.A. (Eds.) (2002). *Community programs to promote youth development*. Washington D.C.: National Academy Press. Huffine, C. (2005). Supporting recovery for older children and adolescents. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 22-23.

[136] Lamb, R., Evans, A.C., & White, W. (2009) *The role of partnership in recovery-oriented systems of care: The Philadelphia experience.* Philadelphia: Department of Behavioral Health and Mental Retardation Services; Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies, 15*, 525-527.

[137] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health*, *19*(1), 5-8.

[138] White, W., Dennis, M., & Godley, M. (2002). Adolescent substance use disorders: From acute treatment to recovery management. *Reclaiming Children and Youth, 11*(3), 172-175.

[139] White, W., Boyle, M., & Loveland, D. (2003). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly, 20,* 107-130.

[140] Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4.

[141] Knight, J.R. (2001). The role of primary care provider in preventing and treating alcohol problems in adolescence. *Ambulatory Pediatrics*, *1*(3), 150-161.

etc.) may sharpen our examination of how these same factors influence adult AOD problems and their resolution.[142]

Recovery Concept and Children: Critics

The major arguments against applying the recovery concept to children, adolescent, and transition age youth services include the following:

- The recovery concept (and other "re" words—*reform*, *redeem*, *rebirth*, *regeneration*, *rehabilitation*—applied to the resolution of severe and prolonged AOD problems) implies return to a previous state of health and functioning rather than the forward developmental trajectory through childhood and adolescence into adulthood; recovery is an adult concept misapplied to children.[143] (Youth-focused recovery models counter this by incorporating the concept of *discovery* into their recovery concept and reinterpreting the meaning of recovery across the life cycle.)
- The term *recovery* is not well understood by stakeholder groups within the child and adolescent service arena; some like the idea of recovery (its hope and optimism), but do not like the word.[144] This is an example of how stigma could lead to the rejection of recovery as an organizing concept.
- The recovery concept fails to "draw attention to some of the issues that are particularly important for children and families."[145]
- The term *recovery* implies a medicalized disease orientation that lacks the developmental perspective critical to children's services.[146]
- The recovery concept, with its focus on the resolution of a particular illness or problem, inhibits a more holistic understanding of the child/family's assets, needs, and aspirations.[147]

[142] Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, *112*, 64-105.

[143] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30. Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[144] Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4.

[145] Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[146] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8. Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30. Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[147] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30.

- Recovery—with its reversal of illness focus—is not appropriate as a conceptual framework for organizing services for young children, but may offer some advantages in the organization of services for adolescents.[148]
- Much of what is called for in recovery-focused systems transformation efforts has already been emphasized in "system of care" models of children's services, e.g., "comprehensive, coordinated, community-based, individualized, culturally competent, child centered and family focused."[149]
- The recovery model's emphasis on self-determination, empowerment, choice, and personal responsibility is inappropriate at worst and at best, difficult to apply to children.[150]
- Many aspects of the recovery concept and recovery-related service practices must be significantly adapted to fit the developmental stages of the adolescent and the developmental stages of adolescent recovery.[151]
- The term *recovery* may set unrealistic and universal expectations of "full cure" for children with severe behavioral health problems.[152] Conveying expectations of "full cure" may also be inappropriate within systems of care that also provide services for children and adolescents with severe developmental disabilities.
- The term *recovery* carries social stigma attached to addiction that should not be indiscriminately applied to children's services.[153] The term *recovery* has been rejected in other arenas in favor of *resilience* on the grounds that recovery carries "negative surplus meaning"—a professional euphemism for the stigma attached to severe substance use and other psychiatric disorders.[154]
- The term *recovery* brings added value but is not inclusive enough; combining these concepts via the phrase *resilience and recovery* best captures the conceptual elements critical to the needed transformation in children's mental health services.[155]

Debate over the application of recovery to the C & A service arena is handicapped by recovery advocates who are not knowledgeable about prevailing concepts in the C & A service arena and child advocates who are unfamiliar with the efforts to nuance the recovery concept within a developmental perspective. Debates over ideas and language from both sides may mask issues of personal, professional, and organizational status and power. Put simply, these discussions can sometimes tap very primitive interests and emotions.

---

[148] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[149] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8.

[150] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[151] Blumberg, D. (2004). Stage model of recovery for chemically dependent adolescents: Part 1—methods and models. *Journal of Psychoactive Drugs*, *36*(3), 323-345. Blumberg, D. (2005). Stage model of recovery for chemically dependent adolescents: Part 2—Model evaluation and treatment implications. *Journal of Psychoactive Drugs*, *37*(1), 15-25.

[152] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[153] Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies*, *15*, 525-527.

[154] Sandler, I.N., Wolchik, S.A., & Ayers, T.S. (2008). Resilience rather than recovery: A contextual framework on adaptation following bereavement. *Death Studies*, *32*, 59-73.

[155] Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

The Philadelphia Focus Groups

The Philadelphia Department of Behavioral Health and Mental Retardation Services conducted a series of focus groups during the summer of 2008 to discuss several basic questions related to the application of the concept of recovery to children and adolescent services and to define core characteristics of an ROSC for children and adolescents. Separate focus groups were hosted for service providers, parents, family members, and representatives from the Youth Leadership Council.

Focus group participants expressed support for blending the concepts of resilience and recovery as an organizing framework for youth services, with the caveat that communicating the definitions of and relationship between these two terms throughout the behavioral health care system would enhance clarity of service planning and the quality of service practices. Common domains of activity/focus were defined that were shared by both the recovery and resiliency concepts and that needed definition and refinement in the context of children's services. These domains included:

- developmentally-informed models of care,
- family inclusion/direction and leadership,
- peer support and leadership,
- continuum of support (versus continuum of care), e.g., support that includes but transcends professional treatment and embraces prevention activities,
- community integration and mobilization of community recovery/resiliency support resources,
- trauma-informed care (and addressing violence within the trauma framework), and
- culturally competent care.

One of the priorities expressed in the focus groups was the need for models and mechanisms of family partnership/leadership and family-focused programming. Potential strategies discussed included:

- youth advisory boards/family advisory councils,
- family representation on policy boards,
- development of grassroots family advocacy organizations,
- new strategies of family assessment and engagement,
- formal family orientation/education programs,
- use of family advocates by treatment organizations,
- family-inclusive treatment,
- family support groups,
- family-focused alumni activities,
- parenting education groups/classes,
- development of clinical and family peer recovery support service options for family members (children and siblings in particular) of all persons admitted for addiction treatment, and
- development of new family peer support programs.

A group of youth much discussed in the Philadelphia focus groups was transition age youth who were "aging out" of the child service system with little transitional support when they were no longer eligible to continue receiving services. It was hoped that new approaches to such transition planning could be developed given the ROSC emphasis on long-term, stage-appropriate recovery support.

The Voices of Youth

Before outlining recommendations based on this review, we thought it appropriate to give the final words of input of the 16 youth who participated in recent focus groups in Philadelphia. Here were some of the sentiments expressed by those young people.

Understand me, don't force things on me, don't have pre-judgments/assumptions based on what you read about me. Learn to know me and take a fresh approach.

Don't use the chart except to know the worst thing I am capable of.

Try to get to know me. Connect with me on a personal level. Get to understand my point of view. Ask me relaxed questions, don't drill me. Ask me "what is going on in your life right now?"

Don't have my family involved unless it is okay with me.

List the positive stuff about me that you see; that helps me to open up. Look for the talents I have as a person, sometimes you might figure it out before me. Build a base with me (of relationship), I can tell a lot about you from your face, from your tone of voice.

Tell me something about yourself. If I know anything about you beyond what degrees you have, it helps me to open up. But don't tell me too much about yourself. I had a therapist who told me all her troubles, that wasn't why I was there.

Don't use words I don't understand…I am already scared, make me feel safe.

Be a human being I can connect with; don't use stuff out of books.

Don't blow things out of proportion, just because I make a mistake doesn't mean I am oppositional or sick, it just means I made a mistake.

Don't diagnose me without cause just because I have to have a diagnosis to get funding, and don't medicate things that can be talked out.

A peer counselor would help because you can't trust school counselors. Except for one who helped set up a peer group at school with kids who were going through the same thing as me. That helped me a lot.

There is so much violence in the community it isn't safe to be connected there.

I disagree. I think we need to be connected to good things that are going on in the community.

You go where you get respect and feel powerful, and that may be a gang in the community.

I had nowhere to go, nothing to do but then someone sent me to the PAL center. There were activities there and adults (mostly cops) to relate to. Therapists need to know these resources.

Summary and Recommendations

So what are the "take home" messages from this sweeping discussion of the use of recovery as an organizing concept for children and adolescent services and the role of such services within efforts to transform addiction treatment and the larger communities in which treatment is imbedded into recovery-oriented systems of care? Several points seem critical:

- A recovery-focused transformation in behavioral healthcare is underway in the United States and other countries, but the implications of such transformation processes on child and adolescent (C & A) services have not been fully defined.
- Recovery offers "added value" as an organizing concept for C & A services, but its greatest potential within the C & A service arena lies in its integration with the concepts of resilience and resistance.
- Recovery as an organizing concept has multiple applications to the C & A service arena:
    1. the achievement of sobriety, global health, and citizenship by children, adolescents, and transition age youth experiencing a substance use disorder,
    2. reversing the developmental insults experienced by children and adolescents who have been exposed to the addiction of a parent or sibling, and
    3. reducing the risks of intergenerational transmission of AOD problems.
- The concept of recovery has particular utility within the C & A services arena in light of the lowered age of onset of AOD use and the increased prevalence of adolescent substance use disorders.
- Treatment resources for adolescent substance use disorders have increased dramatically in the United States, but brief biopsychosocial stabilization is often followed by resumption of AOD use and its concomitant problems. Efforts are needed to extend acute treatment to sustained, post-treatment recovery support.
- *Recovery management* as a philosophy of treatment has much to offer adolescents and transition age youth with severe and complex AOD problems but could generate iatrogenic effects (harm in the name of help) if indiscriminately applied to all AOD-using youth.
- The emerging conceptualization of the core elements of a *recovery-oriented system of care* (ROSC) for children, adolescents, and transition age youth has much in common with earlier organizing frameworks (e.g., system of care and positive youth development) for children and adolescent services.
- It is crucial that a youth-focused ROSC reflect the full integration of primary prevention, early intervention, clinical treatment, and non-clinical recovery support services.
- Arguments for and against the use of recovery as an organizing construct for C & A services are not mutually exclusive. Strategies should be developed that capitalize on the positive additions recovery brings to C & A services and that minimize untoward effects that the application of this concept could generate within C & A services.
- There is growing consensus that an ROSC for C & A should be designed to:

    1. Assure youth and parent involvement in the planning, design, conduct, and evaluation of prevention, early intervention, treatment, and post-treatment recovery support services.
    2. Instill traits and experiences known to serve as protective factors (competence, confidence, attachment, flexibility, opportunity).
    3. Enhance parenting skills, elevate supervision patterns, and re-establish/strengthen family rituals of adults and their partners being treated for a behavioral health disorder.[156]

[156] Sankaran, L., Muralidhar, D., & Benegal, V. (2006). *Strengthening resilience with families in addiction treatment*. Unpublished Paper.

4. Reduce family, neighborhood, and community stressors.
5. Promote "positive chain reactions"—saturated support, guidance, and multiple opportunities during periods of elevated risk.[157]
6. Provide access to family counseling and counseling for the children and adolescents of adults undergoing addiction treatment. Sankaran[158] advocated that all addiction treatment programs include programs for families and children that focused on improved parenting and equipping children with specific skills (self-esteem, coping, conflict resolution, and assertiveness) to enhance resilience.
7. Provide youth-to-youth and parent-to-parent peer-based recovery support services.[159]
8. Assure AOD-involved children and adolescents a continuum of support that spans pre-recovery identification and engagement, recovery initiation and stabilization, recovery maintenance, and enhanced quality of personal/family life in long-term recovery.[160]
9. Provide assertive approaches to continuing support following specialized addiction treatment.[161]
10. Assure transitional supports for youth who are aging out of the child service system.

The following recommendations are offered as points for continued discussion as the City of Philadelphia continues its behavioral health care systems transformation process and seeks to fully involve C & A services within that transformation process.

The Concepts and Language of Systems Transformation

1. Expand the Language of Systems Transformation. The phrase "supporting recovery, building resilience, and enhancing self-determination" ("recovery, resilience, and self-determination" for short) to describe systems transformation efforts offers a means of bridging the three DBH/MRS service arenas (addiction, mental health, and developmental disabilities) and a framework for integrating primary prevention, early intervention, treatment, and non-clinical recovery support services. Discussions of the common and distinguishing features of positive recovery, resilience, resistance, youth development, and systems of care may enhance our capacity to "develop complex, ecologically-based interventions that address the child in the context of family and community."[162]

---

[157] Rutter, M. (2005). Natural experiments, casual influences, and policy development. In M. Rutter, & M. Tienda (Eds), *Ethnic variations in intergenerational continuities and discontinuities in psychosocial features and disorders*. New York & London: Cambridge University Press.

[158] Sankaran, L., Muralidhar, D., & Benegal, V. (2006). *Strengthening resilience with families in addiction treatment*. Unpublished Paper.

[159] *Blamed and ashamed.* (2001). Alexandria, VA: Federation of Families for Children's Mental Health.

[160] 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

[161] 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.

[162] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

2. Elevate Asset-Focused Language. Services for children, adolescents, and transition age youth should focus on strengths of individuals, families, and communities. Elevating the concepts of *recovery*, *resiliency*, *protective factors,* and *recovery capital* within DBH/MRS could underscore this emphasis on personal, family, and community assets.
3. Explicitly Define "Youth." Conduct all discussions of youth service needs within a framework that distinguishes the differences in these needs for children, adolescents, and transition age youth.

Representation and Leadership

1. Model Representation/Leadership within DBH/MRS. Designate positions within the Office of Addiction Services Advisory Board for youth and family representation.
    - Recruit youth and family members for inclusion in key DBH/MRS leadership development activities, e.g., Peer Group Facilitation Training, Recovery Foundations Training, Peer Leadership Academy, and Storytelling Training.
    - Designate leadership positions on Advisory Boards for youth and family representation.
    - Involve youth and family members in planning the redesign of the service system.
    - Facilitate ways for youth and family members to participate in critical evaluation tasks such as conducting focus groups with peers, assisting with the development of satisfaction surveys, etc.
    - Develop separate youth and family advisory councils that have direct access to the leadership within the system.
    - Create expectations for youth and family leadership within provider agencies and align monitoring processes to assess provider compliance.
    - Involve transition age youth and families in the monitoring of services.

2. Encourage Representation/Leadership in Behavioral Health Care Network via dissemination of papers on best practices and provision of technical assistance.

Recovery Visibility of Youth

1. Establish and Monitor Youth Recovery Prevalence. Conduct, evaluate, and publicly disseminate recovery prevalence survey data (household and school surveys) for youth 18 years of age or younger. (Work with existing surveys to assure inclusion of questions that allow reporting of youth recovery prevalence.)
2. Encourage and support a vanguard of recovering young people whose life circumstances allow and who are called to put a face and voice on recovery among young people.

Collaboration and Partnership

1. Work with Mayor's Blue Ribbon Commission on Children's Behavioral Health and the Office of Addiction Services to integrate the concepts of resilience and recovery at planning and service practice levels.

Develop a Continuum of (Personal/Family/Community) Recovery Support

1. Replace the concept of "continuum of care" with "continuum of support" to provide a broader conceptual umbrella to integrate primary prevention, early intervention, clinical treatment, non-clinical recovery support services, recovery community building activities,

and advocacy of policies aimed at enhancing the resilience and recovery of children and adolescents.

2. Explore ways to nest the process of recovery and wellness in young people's natural environments rather than focusing solely on how to get youth with AOD-related problems into treatment. These strategies might include:
    - partnerships with athletic clubs, neighborhood groups, recreation centers, libraries, faith communities, local shopping centers to conduct prevention activities, outreach, early identification/intervention,
    - conducting youth-focused surveys of community recovery capital (Mapping AOD problems indicator data for youth, youth-focused treatment, and recovery support resources by zip code to identify areas of unmet service needs, to evaluate the effects of neighborhood-targeted service projects, and to identify areas in the community that need additional recovery supports), and
    - exploring how indigenous community resources can be used to extend post-treatment support for youth and families from a few weeks or months to the years spanning the transition from adolescence into young adulthood.

3. Support expanded prevention and early intervention strategies, particularly among high risk youth to prevent or postpone use of intoxicants. This would entail:
    - forging partnerships with schools, faith community, etc. to raise awareness and increase community level resources (protective factors/recovery capital) that can enhance the health of at risk and recovering youth, and
    - lowering the threshold of engagement for substance-involved youth, e.g., viewing motivation as a service/support outcome rather than a requirement for service/support initiation and shifting from confrontational to motivational methods of engagement and support.

4. Utilize an expanded continuum of support model with adolescents and transition age youth with severe and complex AOD problems**.** Explore the use of recovery check-ups (post-treatment monitoring and support) and formal systems of peer-based recovery coaching for adolescents with severe and prolonged AOD problems—saturating such support in the first 90 days following primary treatment.[163]

Practice Guidelines

1. Develop distinct recovery/resiliency-oriented practice guidelines for children/adolescents within all practice guideline documents.
2. Explore development of a wide range of youth-to-youth and parent-to-parent peer recovery support services, including family-to-family outreach.[164]

Assessment and Treatment/Recovery Planning

[163] 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.

[164] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

1. Encourage the use of global screening and assessment procedures that address multiple youth and family life domains, as opposed to problem-specific approaches.
2. Encourage holistic approaches to adolescent care and support, e.g., multidisciplinary and multi-agency intervention models that can provide an integrated response to youth and families experiencing multiple challenges.
3. Encourage the transition from professionally-directed treatment plans to personalized, family- and youth-directed recovery plans.[165]
4. Ensure that treatment services are linked to meaningful goals/desires/activities for each young person.
5. Focus on development of service plans that build competencies in multiple domains (social, emotional, cognitive, etc.) rather than focus only on the remediation of deficits or problem behaviors.

Recovery-Focused Treatment

1. Provide youth and families experiencing AOD-related problems access to evidence-based models of treatment, including family-focused approaches to treatment.
2. Provide family-focused education, professional and peer-based recovery coaching, and continuing care support groups.
3. Provide advocates to help families navigate increasingly complex service systems.
4. Enhance parenting skills, elevate supervision patterns, and re-establish/refine/strengthen family rules and rituals.

Develop a Youth/Family-Focused Peer Recovery Culture

1. Explore the development of a wide range of youth-to-youth and parent-to-parent peer recovery support services, including family-to-family outreach.[166]
2. Work with local service committees of recovery mutual aid fellowships to expand the availability of young people's recovery support meetings and persons willing to sponsor young people entering recovery.
3. Utilize assertive linkage procedures between adolescent treatment and local recovery support groups.[167]
4. Explore such peer to peer services as:
    - peer-based adolescent outreach and engagement efforts that are based in natural support settings such as schools, places of worship, community recreation centers, etc.,
    - adolescent and family peer-facilitated support and education groups within treatment settings, particularly within residential treatment facilities,
    - peer-to-peer continuing support services available to youth and families to help sustain the gains made in the treatment context,
    - technology-based peer support strategies that leverage the growing centrality of technology within the daily lifestyle of adolescents, e.g., the use of social networking websites and text messaging for peer support and recovery coaching,

[165] Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42.

[166] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

[167] 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.

- adolescents should be engaged in determining what kinds of peer support activities and roles would be helpful in the system, and how these supports might be structured to maximize utilization,
- web-based peer supports designed to educate and support families, and
- recruitment and training of younger staff (and young people in recovery) to work with youth.

Evaluate Effects of Systems Transformation on C & A Services

1. Provide a Quality of Care Report Card for the major DBH/MRS-funded C & A service providers.
2. Assure the inclusion of parents and siblings affected by youth substance use disorders and youth in recovery from such disorders in the planning, design, conduct, and evaluation of substance-related services for youth.[168]
3. Conduct a youth-focused survey of community recovery capital. Map AOD problems indicator data for youth-focused treatment and recovery support resources by zip code to identify areas of unmet service needs and to evaluate the effects of neighborhood-targeted service projects.

These recommendations, though grounded in the scientific literature and the growing body of experiential knowledge in the City of Philadelphia, constitute a starting point for continued discussion.

Acknowledgments: Work on this paper was supported by the Great Lakes Addiction Technology Transfer Center/Center for Substance Abuse Treatment/Substance Abuse and Mental Health Services Administration (#5 UD1 T1013593-07), the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS), and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (HHSS2832007006I/TO HHSS28300003T Subcontract No: s8440). The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of DBH/MRS, CSAT, SAMHSA, DHHS, or the Federal Government.

[168] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

Appendix A: Definitions of Addiction Recovery

Recovery is "overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety."[169]

"Recovery is the experience of a meaningful, productive life within the limits imposed by a history of addiction to alcohol and/or other drugs. Recovery is both the acceptance and transcendence of limitation."[170]

Recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles."[171]

Recovery means that someone is "trying to stop using alcohol or drugs."[172]

"The term *Wellbriety* is an affirmation that recovery is more than the removal of alcohol and other drugs from an otherwise unchanged life. Wellbriety is a larger change in personal identity and values and a visible change in one's relationship with others. It is about physical, emotional, spiritual, and relational health. Wellbriety is founded on the recognition that we cannot bring one part of our lives under control while other parts are out of control. It is the beginning of a quest for harmony and wholeness within the self, the family and the tribe."[173]

"Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."[174]

"Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life."[175]

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."[176]

---

[169] ASAM (2001). *Patient placement criteria for the treatment of substance use disorders* (2nd edition). Chevy Chase, MD: American Society of Addiction Medicine.

[170] White, W. (2002). *An addiction recovery glossary: The languages of American communities of recovery*. First posted at www.bhrm.org 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.

[171] Anthony, W. A., Rogers, E. S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, *39*(2), 101-114.

[172] Peter D. Hart Research Associates (2004). *Faces and Voices of Recovery Public Survey*. Washington D.C.: Peter D. Hart Research Associates.

[173] *The red road to wellbriety.* (2002). Colorado Springs, CO: White Bison, Inc.

[174] Recovery Advisory Council, Philadelphia Department of Behavioral Health, 2005

[175] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report*. (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

[176] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228.

"Long-term recovery is an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety)."[177]

Appendix B: Definitions of Resilience

Resilience is the "ability of individuals to overcome adversity."[178]

"Resilience refers to a process of adaptation whereby individuals learn to overcome destabilizing effects resulting from traumatic experiences of greater or lesser severity."[179]

"Resilience…manifests itself as successful adaptation at the individual level, despite harmful circumstances or life events normally considered risk factors from the standpoint of adaptation."[180]

"Resilience is the ability of individuals to remain healthy even in the presence of risk factors."[181]

"Resilience is a dynamic process encompassing positive adaptation within the context of significant adversity."[182]

[177] 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

[178] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

[179] Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte á la toxicomanie).

[180] Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte á la toxicomanie)

[181] National Center for Mental Health Promotion and Violence Prevention. (2009). *Risk and Resilience 101*. Retrieved April 22 from http://www.promoteprevent.org.

[182] Luthar, S.S., Cichetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543-562.



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). Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls*. Alcoholism Treatment Quarterly*, 28, 256-272. Posted at www.williamwhitepapers.com

Non-clinical Addiction Recovery Support Services: History, Rationale, Models, Potentials, and Pitfalls1

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

For more than 150 years, the transition from intractable addiction to stable recovery has often involved two quite different worlds: 1) professionally-directed addiction treatment aimed at biopsychosocial stabilization and recovery initiation, and 2) recovery mutual aid that has served as a medium of recovery initiation/stabilization and long-term recovery maintenance. A third sphere, nonclinical recovery support services, is rapidly emerging as a portal of entry into and a bridge between these two worlds. This article identifies factors related to the rapid growth of peer-based recovery support services, describes the organizational contexts in which they are being imbedded, outlines the variations in how the roles of recovery support specialists are being defined, and discusses the potentials and possible pitfalls of such services.

Key Words: Recovery support services, recovery coach, peer specialist, relapse prevention

Introduction

Peer-based (non-clinical) recovery support services (P-BRSS) are growing rapidly within the addictions arena. Six historically significant shifts constitute the soil from which P-BRSS are emerging: 1) the international growth and diversification of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004b), 2) the rise of a new grassroots addiction recovery advocacy movement in America (White, 2006a, 2007a , 3) recovery community building activities, e.g., recovery community organizations, recovery homes, recovery schools, recovery ministries/churches, recovery industries, and recovery community centers (Valentine, White, & Taylor, 2007: White, 2001c), 4) the emergence of recovery as an organizing paradigm within the addictions and mental health fields (White, 2005; Gagne, White, & Anthony, 2007; Davidson & White, 2007), 5) calls to extend 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), and 6) growing interest in diverse 1 This article incorporates and updates material from White, W. (2004a). The history and future of peer-based addiction recovery support services. Presented at the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. 2 (religious, spiritual, secular, gender-specific, culturally-nuanced, and medication-assisted) pathways of recovery initiation and maintenance (White & Kurtz, 2006).

These trends have also sparked interest in recovery-related research and moved the concept of recovery to the center of federal and state behavioral health policy and programming initiatives. Examples of the latter include two Center for Substance Abuse Treatment initiatives--the Recovery Community Services Program (RCSP) and the Access to Recovery program (ATR)--that have collectively exerted considerable influence on the recent spread of P-BRSS. This article provides a brief overview of the history of P-BRSS, the rationale for such services, and the competing organizational contexts in which such services are arising. The article concludes with a brief discussion of potential pitfalls related to P-BRSS.

Historical Perspectives

Peer support for addiction recovery is rooted in the long and rich history of recovery mutual aid societies in America. This history spans 18th and 19th century Native American "recovery circles" (i.e., abstinence-based healing and religious/cultural revitalization movements), the Washingtonians (1840s), abstinence-based fraternal temperance societies (1840s-1870s), the Dashaway Association (1859), the Red Ribbon Reform Clubs (1874), the Drunkard's Club (1872), the United Order of Ex-Boozers (1914), Alcoholics Anonymous (AA) (1935), Narcotics Anonymous (1953), Twelve Step adjuncts (e.g., the Calix Society, JACS, International Doctors in AA), and innumerable Twelve-Step adaptations (related to other drug choices and other excessive behaviors). This history also contains explicitly religious mutual aid alternatives to Twelve Step programs (e.g, Alcoholics Victorious, Alcoholics for Christ, Celebrate Recovery, Ladies Victorious, Free-N-One Recovery, Overcomers Outreach, and Millati Islami), secular recovery support alternatives (e.g., Women for Sobriety, Secular Organization for Sobriety, LifeRing Secular Recovery, and SMART Recovery®), as well as moderationbased alternatives (Moderation Management). Also noteworthy is the marked growth in culturally grounded addiction recovery support groups within Native American and African American communities (White, 1998, 2001a; Coyhis & White, 2002; Sanders, 2002).

The historical relationship between recovery mutual aid societies and professionally directed treatment institutions is a complex one. Recovery mutual aid societies have birthed treatment institutions as adjuncts to themselves. For example, the Dashaway Association founded the San Francisco Home for the Care of Inebriates. Recovery mutual aid societies have been birthed inside treatment institutions (e.g., founding of the Keeley Leagues by patients of the Keeley Institute). There is a long history of reciprocal referral of individuals between these two cultural institutions, as well as efforts by each to colonize the other (White, 1998).

Early peer-based social support linked to addiction treatment institutions include patient clubs developed within nineteenth century inebriate homes and asylums (Ollapod Club, the Godwin Association) and addiction cure institutes (Keeley Leagues)(1860s1890s), the Jacoby Club of the Emmanuel Clinic in Boston (1910), AA volunteers working within "AA wards" (of general hospitals), "AA farms" and "AA retreats"(1940s1950s), and peer-based supports linked to early halfway houses (1950s). Peer-based social support is more recently evident in self-managed recovery homes (e.g., Oxford Houses), California's "social model" programs, and the volunteer programs and alumni associations of addiction treatment programs (Jason, Davis, Ferrari, & Bishop, 2001; Borkman, Kaskutas, Room, et al, 1998). The latest surge in peer-

based recovery support services is emerging from new grassroots recovery community organizations (RCOs) and by treatment programs trying to extend their continuum of care (White, 1998, 2001a).

The use of paid peer helpers ("peer" defined here as people in addiction recovery hired to serve as guides for others seeking recovery) in the addictions arena also has a long history including recovered and recovering people working as temperance missionaries (1840s-1890s); aides ("jag bosses") and managers of inebriate homes (1860s-1900); Keeley Institute physicians (1890-1920); "friendly visitors" within the Emmanuel Clinic in Boston (1906); lay alcoholism psychotherapists (1912-1940s); managers of "AA farms" and "AA retreats" (1940s-1950s); halfway house managers (1950s); "paraprofessional" alcoholism counselors and professional "ex-addicts" (1960s1970s); credentialed addiction counselors; detox technicians, residential aids, outreach workers, and case managers (1970s-1990s); and, more recently, "recovery coaches," "recovery mentors," "recovery support specialists", "personal recovery assistants," and "peer specialists" (White, 1998, 2000a,b,c). Both paid and volunteer models of peerbased recovery support services are part of larger recovery-oriented system transformation efforts underway at the national (Clark, 2007), state (Kirk, 2007), and local (Evans, 2007) levels.

The Rationale for Peer-Based Recovery Support Services

The justification for peer-based recovery support services comes primarily from three sources. First, such services are a way to historically counter the over-professionalization, bureaucratization, and commercialization of addiction treatment as a social institution. P-BRSS are an attempt to reconnect addiction treatment to the larger and more enduring process of addiction recovery (Morgan, 1995; Else, 1999; White, 2000b), to move the locus of service activity from the treatment institution to the natural environments of those seeking help (White, 2001b), and to facilitate the shift from toxic drug dependencies and an unhealthy dependence on formal helping institutions to a "prodependence on peers" (Nealon-Woods et al., 1995). P-BRSS are also an attempt to humanize a system that, after decades of assault by reimbursement and regulatory authorities, is perceived by recovery advocates as more preoccupied with incomes than outcomes and more focused on the quality of service documentation than the quality of service relationships. Put simply, the service milieus of addiction treatment institutions have become less welcoming and engaging through their maturation. P-BRSS constitute one effort to re-elevate this engagement process. Parallel processes are underway in allied human service fields (Ungar, Manuel, Mealey et al., 2004).

The second rationale for P-BRSS is as a mechanism to correct flaws inherent in the dominant acute care model of addiction treatment. This medically-based model, characterized by a series of discrete activities (screen, assess, diagnose, treat, discharge, terminate service relationship) and directed by a professional over an ever-shortening period of time, is coming under rigorous criticism. Analyses of this acute care model of biopsychosocial stabilization find the system vulnerable in nine performance categories that have implications for P-BRSS (See White, Boyle & Loveland, 2002 for multiple study citations):

- attraction: Only a small percent of those needing services receive services and then do so primarily through external coercion.
- access: Innumerable obstacles inhibit access, and there is high attrition between help-seeking and first appointments.
- retention: Less than half of persons admitted to primary treatment successfully complete treatment.
- dose: A significant portion of addiction treatment clients receive less than the research-based treatment dose recommended by the National Institute on Drug Abuse.
- quality of services: Routine service elements within the acute care model lack scientific evidence of their effectiveness, and

some have been shown to do harm, i.e., confrontation.

- linkage to community recovery support resources: Linkage to recovery communities is mostly of a passive variety—verbal encouragement variety and is plagued by low connection and high drop-out rates.
- continuing care: Only a small percentage of individuals discharged from addiction treatment receive any significant post-treatment continuing care.
- post-treatment lapse and relapse rates: More than half of clients discharged will resume AOD use within 12 months.
- re-admission rates: More than 60% of those admitted to treatment already have prior treatment; nearly 20% have 5 or more prior treatment episodes.

Peer-based recovery support services focusing on pre-treatment engagement, in-treatment retention, assertive linkage to communities of recovery, post-treatment monitoring and sustained recovery coaching, and, when needed, early re-intervention constitute an effort to correct major system performance problems within the acute care model of addiction treatment.

The third rationale for P-BRSS draws upon two sources of literature. The first supports the value of peer-based services to those helped and to the helper—what Riesman (1965, 1990) christened the "helper principle." 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 (Jackson, 2001). The second body of literature contains preliminary research suggesting the potential effectiveness of peer-facilitated models of change (Durlak, 1979; Hattie et al., 1984; Riessman, 1990), particularly within the arena of addiction recovery (Connett, 1980; Galanter et al., 1987; Blum & Roman, 1985). These models include both peer-based recovery support societies and peer-based adjuncts to traditional addiction treatment.

The potential of peer-based models of recovery support has not been subjected to focused and sustained research, but the potential of P-BRSS services in long-term addiction recovery is suggested in study findings that reveal:

- The achievement of stable recovery from addiction can span decades and multiple episodes of treatment (Anglin, Hser, & Grella, 1997; Dennis, Scott, & Hristova, 2002). P-BRSS may provide a mechanism for shortening addiction careers and lengthening recovery careers.
- Addiction recovery begins prior to the cessation of drug use and is marked by extreme ambivalence that continues well beyond the stabilization of sobriety (White & Kurtz, 2006). P-BRSS constitute a resource to manage that ambivalence and achieve a stable stage of recovery maintenance.
- Linkage to recovery mutual aid groups and physical and social environments conducive to recovery can enhance long-term recovery outcomes (Humphreys, Moos, & Cohen, 1997; Fiorentine & Hillhouse, 2000; Timko, Moos, Finney et al., 1999; Morgenstern, Labouvie, McCray et al., 1997; Kaskutas, Ammon, & Wesiner, 2004; Jason, Davis, Ferrari, & Bishop, 2001). P-BRSS constitute a mechanism of assertive linkage to such resources.
- A personal "guide" can help facilitate disengagement from the culture of addiction and entrance into and engagement with a culture of recovery (White, 1996). Those providing P-BRSS serve as such guides.
- The achievement of stable recovery is influenced by recovery capital—the internal and external assets available to initiate and sustain recovery (Granfield & Cloud, 1999). The development of recovery capital is a primary focus of PBRSS.
- Addiction treatment outcomes are enhanced by the provision of ancillary medical, psychiatric, and social services (McLellan, Arndt, Metzger et al., 1993; McLellan, Hagan, Levine et al., 1998; McLellan, Hagan, Levine, Meyers et al., 1999). PBRSS may provide an effective source of linkage to such services.

- The point at which most recoveries become fully stabilized is between four and five years after recovery initiation (Vaillant, 1996; Jin, Rourke, Patterson, Taylor, & Grant, 1998), suggesting the need for sustained monitoring and support that could potentially be provided by P-BRSS.
- Preliminary studies of assertive models of post-treatment "recovery checkups" for adults (Dennis, Scott, & Funk, 2003) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2002) suggest such sustained support can enhance long-term recovery outcomes and can be delivered in face-to-face, telephone-based, or Internet-based formats (McKay, 2005; McKay, Lynch, Shepard, & Pettinati, 2005; Kurtz & White, 2007).

The P-BRSS Role

The range of services provided within the framework of P-BRSS is indicated by the broad range of roles the recovery coach is expected to perform. In earlier publications (White, 2004c, 2006b), I have described the multiple roles of the recovery coach (See Table One).

Table One: Roles of the Recovery Coach

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 selfdestructive 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.

Lifestyle consultant: assists individuals/families to develop sobriety-based rituals of daily living.

A friend: provides companionship.

Also noted were the functions the recovery coach was not expected to serve. The recovery coach is NOT a sponsor (does not perform AA/NA service work on "paid time"), a therapist (does not diagnose or probe undisclosed trauma/"issues"; does not refer to their support activities as "counseling" or "therapy"), a nurse/physician (does not make medical diagnoses or offer medical advice), or a priest/cleric (does not respond to questions of religious doctrine nor proselytize a particular religion/church).

The verbs most frequently used to describe the activities of the recovery coach include engage, elicit, validate, share, express, enhance, orient, help, identify, link, consult, monitor, transport, praise, enlist, encourage, and support. The fact that P-BRSS specialists fulfill all these roles and functions is both a strength and vulnerability of PBRSS models.

Persons providing P-BRSS, rather than being legitimized through traditionally acquired education credentials, tend to be legitimized based on experiential knowledge and experiential expertise (Borkman, 1976).

"It is not the experience of having been wounded or having transcended such wounds that constitutes a credential. It is the extraction of lessons from that experience that can aid others, and a new ethic that transforms that learning into service to others. Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. Experiential expertise requires the ability to use this knowledge to affect sustainable change in self or others. It requires the ability to separate the experience of the helper from that of the person being helped. The dual credentials of experiential knowledge and experiential expertise are granted through the addiction/recovery community "wire"/"grapevine" via storytelling. It is bestowed only on those who offer 2 P-BRSS specialists draw from an eclectic menu of religious and secular concepts and metaphors to anchor the recovery process. 7 sustained living proof of their expertise as a recovery guide within the life of the community (White & Sanders, in press)."

P-BRSS services are best delivered within the recognition of multiple long-term pathways of recovery (White, 1996). The practical implications of this proposition is that the recovery support specialist must acknowledge the legitimacy of these multiple pathways; become conversant with the language, catalytic metaphors, and rituals reflected within these pathways; work to expand the variety of recovery support structures within the communities he or she serves; and develop relationships with the myriad groups representing these pathways. The best P-BRSS also recognize multiple styles of recovery. Such style variations are reflected in the recovery initiation process (transformative change versus incremental change), identity reconstruction (recoverypositive, recovery-neutral and recovery negative identities), and post-recovery interpersonal relationships (acultural, bicultural and culturally enmeshed styles of recovery) (White & Kurtz, 2006). The operational motto of the best P-BRSS specialists is "recovery by any means necessary." It matters little to them whether recovery is initiated without professional assistance (solo or natural recovery), with peer-assistance or professional treatment (affiliated or assisted recovery), or is initiated via peer and professional supports but maintained without such assistance (disengaged recovery) (White & Kurtz, 2006). The focus is on the singular goal of recovery, not a particular method. Such tolerance and respect requires maturity and wisdom.

P-BRSS Models

The definition of the recovery coach role is shaped heavily by the organizational context in which these services are offered. There are currently at least three different contexts through which P-BRSS are being delivered, each of which influences the character of the P-BRSS role and the services offered.

In the medical/clinical model of P-BRSS service delivery, the recovery coach is often a trained professional (most commonly a certified addictions counselor) employed by an addiction treatment institution who is expected to provide recovery coaching responsibilities in addition to other service roles within the organization. For example, an addictions counselor in a residential program may be asked to provide post-treatment telephone-based recovery coaching to clients for whom he or she earlier served as a primary counselor. A variation of this model is the hiring of peer specialists (without professional credentials) to deliver pre-treatment, in-treatment, or post-treatment recovery support services. Within the medical/clinical model, P-BRSS are defined as another "level of care" within the continuum of clinical services and thus have a distinctly clinical orientation. The strength of this model is the potential continuity of support provided to clients before, during, and following addiction treatment. The weaknesses of this model

are that the “peer” is often not really a peer and the tendency in these settings is to turn the recovery coach into a junior therapist by defining the role via the professional ethics, and activities that govern clinical roles in the organization. 3 Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite change in beliefs, behavior, identity, and relationships. 4 Transformative change is characterized by its suddenness, vividness, positiveness, and permanence (Miller & C’de Baca, 2001).

In the P-BRSS community development model, the recovery coach is usually a person in recovery who has been “vetted” via his or her service history within a local community of recovery. In this model, the recovery coach works for a recovery community organization that most often provides three types of services: recovery advocacy, recovery education, and peer-based recovery support services. In this model, P-BRSS are viewed within a framework of community development and cultural revitalization (White, 2003, 2007b), and the agent of healing is viewed not as the recovery coach but the community itself. The recovery coach’s role in this model is to help build recovery support resources in the local community and to link individuals and families to such resources. This model may use paid or volunteer recovery support services or a combination of paid and volunteer roles. The strengths of this model include its capitalization on knowledge of indigenous addiction and recovery cultures, its close connections to natural recovery support resources, and its capacity for a long-term recovery support alliances. One weakness of this model is that advocacy activities can take the recovery coach and the recovery community organization into institutional conflicts that can interfere with services to individuals and families.

In the P-BRSS business model, the services of a recovery coach are offered by an independent for-profit agent. Recovery coaching is being delivered as a private practice service offered mostly by people who have backgrounds in addiction treatment or intervention services. Coaches in these settings offer a varying intensity of services that can include 24-hour supervision and support during the first weeks following an individual’s discharge from addiction treatment. Some recovery coach businesses charge up to $800 a day for recovery coaching and cater to people being discharged from “spa/boutique” treatment settings. The near invisibility of these organizations and the lack of any scientific studies of such private services make further description of this model impossible. Perception of private recovery coach agencies communicated to the author by recovery advocates from around the country range from seeing them as offering a valuable service to those who can afford it to allegations that they are institutional predators who view the relapsing alcoholic and addict as a crop to be harvested for financial profit.

There are substantial barriers to implementing any of the above P-BRSS models. Some of these challenges are conceptual (e.g., failure to see the need for P-BRSS services); disagreements over the definition of “peer”; and conflicts between the P-BRSS emphasis on recovery community building and traditional biopsychological models of problem intervention. Emotional challenges include the failure of traditionally-trained professionals to accept P-BRSS service specialists as legitimate professional peers. Technical and administrative barriers include the lack of empirical models of P-BRSS, the lack of P-BRSS implementation protocols, and challenges complying with treatmentoriented licensing and reporting procedures. Substantial financial barriers also exist, including the lack of financing models for P-BRSS and local and state fiscal austerity that limits new service initiatives.

One of the most critical questions related to P-BRSS is how such services fit within or are connected to the existing addiction treatment continuum of care. There is the possibility that P-BRSS will evolve as a separate system disconnected from the national network of addiction treatment programs. P-BRSS are coming out of a new generation of grassroots recovery advocacy and support organizations that perceive many treatment programs as too preoccupied with their own institutional interests. This

undercurrent of disenchantment and hostility and its sources will need to be openly confronted and resolved if the goal of a system of integrated clinical and recovery support services is to be achieved. Lacking such resolution, the proliferation of P-BRSS and their alienation from mainstream treatment could further fragment a system that is already difficult to navigate.

There is a real question about the best organizational location for recovery support services. The answer to that question will require guidance from community elders, feedback from service consumers, a cost comparison of various models, and research studies to determine if recovery outcomes are enhanced when they are linked to particular types of P-BRSS service delivery sites. As this process unfolds over the next few years, the following principles are suggested as a foundation for interim collaboration.

- P-BRSS and professionally-directed addiction treatment services are complimentary rather than competitive.
- P-BRSS and treatment services should be integrated into a single, seamless continuum of services (regardless of the settings out of which they are delivered).
- P-BRSS specialists and treatment specialists must recognize and respect the special contributions each can make to the recovery process.
- Both P-BRSS specialists and treatment specialists must accurately represent and practice within the boundaries of their education, training, and experience.

The goal is to have all services—professional and peer—become person-oriented, family-oriented, and recovery-focused.

Strengths and Vulnerabilities of P-BRSS

P-BRSS services will require extensive evaluation to determine their effects on addiction and recovery careers. There is particular interest in how P-BRSS can potentially enhance the effectiveness of the existing treatment system. Testing the following hypotheses would be a good starting point for such research. P-BRSS services are predicted to:

- increase the number of people entering addiction treatment,
- decrease the number of people "lost" from waiting lists to enter addiction treatment,
- divert individuals with lower problem severity and higher recovery capital into natural recovery support systems in the community (creating a better stewardship of limited treatment resources),
- enhance treatment retention and completion,
- increase post-treatment abstinence outcomes,
- delay the time period from discharge to first use following treatment (enhancing development of recovery capital),
- prevent lapses from becoming relapses,
- shorten the number, intensity, and duration of relapse episodes following treatment,
- decrease treatment readmission rates (slow the revolving door of treatment),
- decrease the time between relapse and re-initiation of treatment and recovery support services (preserving recovery capital and minimizing personal and social injury),
- result in readmission to less intensive, expensive levels of care,
- reduce attrition in first year affiliation rates with AA and other sobriety-based support groups, and
- enhance recovery capital (e.g., employment, school enrollment, stable housing, healthy family and extended family involvement, sobriety-based hobbies, financial resources) and self-defined quality of life.

At a systems level, P-BRSS offer an opportunity to enhance linkages between the existing treatment agencies and local indigenous recovery support systems; linkages that have eroded due to the regulation and commercialization of addiction treatment. P-BRSS roles may also offer an opportunity to retrieve the best of what was lost on the road to professionalizing the role of addiction counselor; that is, a service relationship based on moral equality, practical

recovery coaching, knowledge of and active linkage to local communities of recovery (White, 2004c).

The strengths and vulnerabilities of P-BRSS are integrally connected. The values of accessibility and working within natural environments have a shadow side of overextension, burn-out and concerns about the physical and psychological safety of P-BRSS specialists. The reciprocal, non-hierarchical nature of the P-BRSS relationship leaves open the danger of boundary violations and abuses of power. The emphasis on continuity of support over time leaves agencies providing P-BRSS struggling to define their recovery support capacity (e.g., how many people can be supported in what manner for how long?). The value of client empowerment and the rebellion against the growing coerciveness of addiction treatment run headlong into dilemmas of how to respond when those we serve pose threats to others. The grassroots P-BRSS movement will need to actively manage the inevitable pull towards specialization, professionalization, and commercialization. Confronting ineffective practices in the existing treatment system, including those within agencies that are experimenting with P-BRSS, and being viewed as competition for scarce funding resources will also align the P-BRSS movement against powerful institutional and professional interests.

The P-BRSS movement also will need to confront how addiction-related stigma can distort its own operations as an organization or organizational unit, potentially leading to "incestuous closure," ideological schisms, the scapegoating of organizational/unit leaders and members, the exploitation of organizational/unit members, and organizational/unit stagnation and implosion (See White, 1997; Janzen, 2001).

Potential Iatrogenic Effects of P-BRSS

The history of addiction treatment is filled with iatrogenic insults (i.e., treatment-caused harm or injury) (White, 1998), and the potential for such effects with P-BRSS requires active prevention and management.

Risk to Service Consumers: Consumers of recovery support services could be injured from incompetent care and through boundary violations (e.g., financial, emotional, and sexual exploitation) in their relationships with P-BRSS service specialists. P-BRSS may require a set of protections analogous to those provided upon entry to addiction treatment (e.g., credentialing, codified ethical standards, complaint procedures, informed consent, confidentiality, clinical supervision), but such mechanisms must be crafted in consultation with consumers and local communities of recovery. Minor adaptations of existing clinically-oriented standards and support procedures would NOT constitute effective protections for the P-BRSS provider or consumer. Efforts are currently underway to develop ethical guidelines for P-BRSS (White, The PRO-ACT Ethics Committee, Popovits, & Donohue, 2007).

Risk to P-BRSS Providers: There are several potential risks to the providers of PBRSS, including vulnerability of exploitation (e.g., excessive hours, low pay/benefits/status, abuses of power in the relationships between P-BRSS specialists and professionals), alienation/isolation from the recovery community, vulnerability of relapse, particularly in organizations or work environments not conducive to personal recovery. Such exploitation and vulnerability of recovering people working in service roles is a hidden story within the rise of modern addiction treatment (Wilson, 1984; White, 1979, 1998).

Risk to P-BRSS Service Organizations: Service organizations will face liability risks related to improper hiring, supervision, and retention of P-BRSS workers who are involved in illegal or unethical conduct. Such liability will need to be actively managed via rigorous screening and hiring procedures, rigorous training and supervision, and the development of clear ethical guidelines governing the delivery of P-BRSS.

Risk to the Community: P-BRSS could also injure the larger recovery community by engendering conflict about such services within mutual aid organizations and by undermining or commercializing the service ethic within

such organizations. The goal of P-BRSS services is to exponentially expand natural recovery support services within each community, not replace voluntary support services with paid services. If the result of PBRSS services is the latter, the harm will be a significant one (McKnight, 1995).

Closing Reflection

The current acute care model of addiction treatment is in need of redesign and renewal. P-BRSS could become a superficial (i.e., token) appendage to this broken system, or it could become a catalyst for recovery-focused system transformation. PBRSS could help shift the addiction treatment system from serial episodes of encapsulated acute care to a model of sustained recovery management. So typical of the many paradoxes of recovery, addiction treatment as a system of care might well be redeemed by those for whom it was originally designed to serve. On the other hand, if PBRSS are over-professionalized and commercialized into an ever-growing and overextended recovery support services industrial complex and if that paid support erodes the service ethic within local communities of recovery, then the experiment with P-BRSS will have failed horribly.

Acknowledgement: The views expressed here are my own, conveyed through my roles as a recovery historian and recovery advocate, and should not be interpreted as reflecting the policies or opinions of organizations with whom I have been associated or who have provided financial support for my work.

References

Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. *Psychology of Addictive Behaviors*, 11(4), 308-323.

Blum, T., & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and nonalcoholic alcoholism counselors: A survey. *Journal of Health and Social Behavior*, 26(4), 365-378.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456.

Borkman, T.J., Kaskutas, L.A., Room, J., Bryan, K., & Barrows, D. (1998) An historical and developmental analysis of social model programs. *Journal of Substance Abuse* Treatment, 15(1), 7-17.

Clark, W. (2007). Recovery as an organizing concept. Accessed June 26, 2007 at http://www.glattc.org/Interview%20With%20H.%20Westley%20Clark,%20MD,%20JD,%20MPH,%20CAS,%20FASAM.pdf.

Connet, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, 15, 585-589.

Coyhis, D., & White, W. (2002). Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly*, 20(3/4), 157- 165.

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*, 34(2), 1094-3412.

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, 339–352.

Dennis, M. L., Scott, C. K., & Hristova, L. (2002). The duration and correlates of substance abuse treatment careers among people entering publicly funded treatment in Chicago [Abstract], *Drug and Alcohol Dependence*, 66(Suppl. 2), 44.

Durlak, J. (1979). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 86, 80-92.

Else, J. D. (1999). Recovering recovery. *Journal of Ministry in Addiction & Recovery*, 6(2), 11-23.

Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Accessed June 26, 2007 at 13 http://www.glattc.org/Interview%20With%20 Arthur%20C.%20Evans,%20PhD.p df.

Fiorentine, R., & Hillhouse, M. (2000). Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *Journal of Substance Abuse Treatment*, 18(1), 65-74.

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.

Galanter, M., Castaneda, R., & Salamon, I. (1987). Institutional self-help therapy for alcoholism: Clinical outcome. *Alcoholism: Clinical and Experimental Research*, 11(5), 424-429.

Godley, M., Godley, S., Dennis, M., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 95, 534-541.

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, 58, 231-238.

Jackson, S.W. (2001). The wounded healer. *Bulletin of the History of Medicine*, 75, 1- 36.

Janzen, R. (2001). *The rise and fall of Synanon*. Baltimore: Johns Hopkins University Press. Jason, L. A., Davis, M. I.,

Ferrari, J. R., & Bishop, P. D. (2001) Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, 31(1), 1-27.

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(6), 640- 646.

Kirk. T. (2007). Creating a recovery-oriented system of care. Accessed June 26, 2007 at htttp://www.glattc.org/Interview%20With%2 0Thomas%20A.%20Kirk,%20Jr.,%2 0PhD.pdf.

Kurtz, E., & White, W. (2007). Telephone- and Internet-based recovery support services. Chicago, IL: Great Lakes Addiction Technology Transfer Center

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, 100(11), 1594-1610.

McKay, J.R., Lynch, K.G., Shepard, 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.

McKnight, J. (1995). *The careless society: Community and its counte*rfeits. New York: Basic Books.

McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. F., & O'Brien, C. P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, 269(15), 1953-1959.

McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., &

Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, 93(10), 1489-1499.

McLellan A. T., Hagan T. A., Levine M., Meyers, K., Gould, F., Bencivengo, M., Durell, J., & Jaffe, J. (1999). Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence*. 55(1-2), 91–103.

McLellan, A.T., Lewis, D.C., O'Brien, C.P, & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695.

Miller, W. R., & C'de Baca, J. (2001). *Quantum change*. New York: Guilford.

Morgan, O. J. (1995). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly*, 12(1), 59-71.

Morgenstern, J., Labouvie, E., McCray, B. S., Kahler, C. W., & Frey, R. M. (1997). Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology*, 65(5), 768-777.

Nealon-Woods, M., Ferrari, J., & Jason, L. (1995). Twelve-Step program use among Oxford House residents: Spirituality or social support for sobriety? *Journal of Substance Abuse*, 7, 311-318.

Riessman, F. (1965). The "helper-therapy" principle. Social Work, 10, 24-32. Riessman, F. (1990). Restructuring help: A human services paradigm for the 1990s. *American Journal of Community Psychology*, 18, 221-230.

Sanders, M. (2002). The response of African American communities to addiction: An opportunity for treatment providers. *Alcoholism Treatment Quarterly*, 20(3/4), 167-174.

Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Longterm treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, 60(4), 437-447.

Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work*, 49(4), 550-561.

Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry*, 53(3), 243-249.

Valentine, P., White, W., & Taylor, P. (2007) The recovery community organization: Toward a definition. Posted at http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf. White, W. (1979).

Relapse as a phenomenon of staff burnout in recovering substance abusers working as counselors. Rockville, MD: HCS, Inc.

White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. (1997). *The incestuous workplace*. Center City, MN: Hazelden.

White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000a). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, 18(1), 1-23.

White, W. (2000b). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly*, 18(2), 1-25.

White, W. (2000c). The role of recovering physicians in 19th century addiction medicine: An organizational case study. *Journal of Addictive Diseases*, 19(2), 1-10.

White, W. (2001a). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly*, 19(1), 1-22.

White, W. (2001b). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly*, 19(4), 1-32.

White, W. (2001c). Recovery university: The campus as a recovering community. *Student Assistance Journal*, 13(2), 24-26.

White, W. (2003). The road not taken: The lost roots of addiction counseling. *Counselor*, 4(2), 22-23.

White, W. (2004a). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.

White, W. (2004b). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction*, 99, 532-538.

White, W. (2004c). Recovery coaching: A lost function of addiction counseling? *Counselor*, 5(6), 20-22.

White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.

White, W. (2006a). 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.

White, W. (2006b). Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity. (Monograph) Philadelphia, PA: Philadelphia Department of Behavioral Health.

White, W. (2007a). The new recovery advocacy movement in America. *Addiction*, 102, 696-703.

White, W. (2007b). "With a Little Help from my Friends": The development and mobilization of community resources for the initiation and maintenance of addiction recovery. Prepared for Second Betty Ford Consensus Conference: Extending the Benefits of Addiction Treatment, October 3-4.

White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, 20(3/4), 107-130.

White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.

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 16 support services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. & Sanders, M. (in press). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*.

Wilson, D. (1984). Impaired counselor: The ignored problem of the new profession. *Counselor*, July/August, p. 5.



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 UK Recovery Academy (Best. D., Bamber, S., Gilman, M., Groshkova, T., Honor, S., McCartney, D. & Yates, R. & White, W.) (2010). Recovery and straw men: An analysis of the objections raised to the transition to a recovery model in UK addiction services. *Journal of Groups in Addiction and Recovery*, 5, 264-288. Posted at **www.williamwhitepapers.com**

Recovery and Straw Men: An Analysis of the Objections Raised to the Transition to a Recovery Model in UK Addiction Services

Abstract

In both Scotland and England, the current drug strategies (HM Government, 2008; Scottish Government, 2008) have demonstrated a clear commitment to an integrated recovery oriented model of treatment for drug problems, which represents a significant change in focus towards a more person-centred and individualised philosophy for the delivery of drug treatment in the UK. This change has met with some resistance from a range of professionals in the UK and the purpose of the article is to make explicit these concerns and objections, classify them and examine their foundations. A group of UK academics, policy makers and practitioners, who met under the auspices of the UK Recovery Academy, agreed to collate a list of objections to the viability of recovery approaches in the addiction field and to assess the merits of each concern. This process resulted in a total of 26 objections that are reviewed. The article concludes with an overview of the questions remaining unanswered in the UK, and an assessment of the position of the 'recovery movement' in the UK addictions field.

For Full Text: http://www.informaworld.com/smpp/content~content=a929460216

Recovery Academy

www.recoveryacademy.org
info@recoveryacademy.org

2010 Conference
William L. White statement

Dear Friends of the Recovery Academy,

Please accept my regrets that I cannot be with you in person to participate in these proceedings. I do want to convey to each of you the importance of the work that the Recovery Academy is pursuing. A growing body of scientific research has helped unravel the etiological pathways of addiction and evaluate the short-term outcomes of various professional interventions aimed at reducing or eliminating severe alcohol and other drug problems. But from the standpoint of science, we know very little about the long-term lived experience of addiction recovery.

We know a great deal about the prevalence and patterns of drug problems, but very little about the prevalence, pathways, styles and stages of long-term recovery. Our studies of addiction pathology and addiction treatment contain scant reference to the reality of long-term recovery. They have not substantially altered the social and professional stigma attached to these problems nor have they created the great clinical breakthroughs that so many suffering individuals and families have prayed for. If there is an unexplored frontier in addiction research today, it is the recovery frontier. The Recovery Academy has the potential of entering into partnership with individuals and families in recovery to explore this frontier.

Let me convey to you on behalf of people in long-term recovery the importance of this endeavor. People seeking and in recovery are inundated by brain slides illustrating the neurobiology of addiction and by proclamations that our brains have been “hijacked,” but we are shown no slides that promise, or illustrate the range and pace of, neurobiological healing. We are exposed to the growing knowledge of addiction risk factors, but we find no maps charting the secular, spiritual and religious pathways of long-term recovery. We find no guidance on how these pathways differ across cultural contexts and personal characteristics. We find science silent on some of our most basic questions. We know little about the transition from initial recovery initiation to long-term recovery maintenance. We know little about how recovery is managed over the life cycle or how early age of onset of recovery differs from onset of recovery late in life. We know little about the roots and recourse of relapse after prolonged recovery. We know how devastating addiction is to families, but we are offered no science-guided information on the long-term reconstruction of family relationships, roles, rules and rituals. We are told that our children are at increased risk for developing similar problems, but we are not told how to enhance their resilience. No one can tell us whether our own recovery status influences these vulnerabilities or the course of these problems should they develop. So let me make a plea to each of you: Help us answer questions that will make a difference in the lives of individuals and families who are seeking recovery and to those who are striving to live full and meaningful lives

in recovery. They deserve our best efforts and our willingness to enter into respectful partnership with them as we move forward.

Finally, let me assure you that studying the solution to addiction is far more personally and professionally rewarding than studying the devastating pathologies of addiction. The recovery frontier is calling. I wish the Recovery Academy and each of you godspeed on your journey into that frontier.

Bill White

Author, Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement
Volunteer Consultant, Faces and Voices of Recovery, USA
www.williamwhitepapers.com



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). Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls. *Alcoholism Treatment Quarterly*, 28, 256-272. Posted at **www.williamwhitepapers.com**

Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls.

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

For more than 150 years, the transition from intractable addiction to stable recovery has often involved two quite different worlds: 1) professionally-directed addiction treatment aimed at biopsychosocial stabilization and recovery initiation, and 2) recovery mutual aid that has served as a medium of recovery initiation/stabilization and long-term recovery maintenance. A third sphere, non-clinical recovery support services, is rapidly emerging as a portal of entry into and a bridge between these two worlds. This article identifies factors related to the rapid growth of peer-based recovery support services, describes the organizational contexts in which they are being imbedded, outlines the variations in how the roles of recovery support specialists are being defined, and discusses the potentials and possible pitfalls of such services.

RECOVERY-ORIENTED METHADONE MAINTENANCE

William L. White, MA

Lisa Mojer-Torres, JD

Northeast ATTC
Unifying science, education and services to transform lives.

Great Lakes ATTC
Unifying science, education and services to transform lives.

dbhmrs
recovery | resiliency | self-determination

RECOVERY-ORIENTED METHADONE MAINTENANCE

William L. White, MA

Lisa Mojer-Torres, JD

Great Lakes Addiction Technology Transfer Center

Philadelphia Department of Behavioral Health and Mental Retardation Services

Northeast Addiction Technology Transfer Center



Northeast
ATTC
Unifying science, education
and services to transform lives.



dbhmrs
recovery | resiliency | self-determination



Great Lakes
ATTC
Unifying science, education
and services to transform lives.

Published by the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center

Great Lakes Addiction Technology Transfer Center
Jane Addams College of Social Work
University of Illinois at Chicago
1640 West Roosevelt Road, Suite 511 (M/C 779)
Chicago, Illinois 60608-1316

Philadelphia Department of Behavioral Health and Mental Retardation Services
1101 Market Street
Philadelphia, PA 19107

Northeast Addiction Technology Transfer Center
Institute for Research, Education and Training in Addictions
Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, Pennsylvania 15219

© 2010

This publication was written by William L. White and Lisa Mojer-Torres and jointly published by the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center, in part under 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 publication 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 authors. 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. For more information on obtaining copies of this publication, call (312) 996-0966.

At the time of publication, Pamela S. Hyde, JD served as the Administrator, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services; H. Westley Clark, MD, JD, MPH, served as CSAT Director; Catherine D. Nugent, M.S., M.S., LCPC, CP/PAT, served as Chief, Quality Improvement and Workforce Development Branch, Division of Services Improvement, SAMHSA/CSAT; and Donna M. Doolin, LSCSW, served as the ATTC Project Officer/Public Health Advisor, Quality Improvement and Workforce Development Branch, Division of Services Improvement.

The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of these sponsoring agencies. No official support of or endorsement by any of the agencies for these opinions or for particular resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

Produced under grants and contracts funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Center for Substance Abuse Treatment, 5600 Fishers Lane, Rockwall II, Suite 618, Rockville, MD 20857, 301-443-5053 and the Philadelphia Department of Behavioral Health/Mental Retardation Services. Its contents are solely the responsibility of the author and do not necessarily represent the official views of these agencies.

Grants: No. 2 UD1 TI013404-06 and No. 6 UD1 TI13593-02-3

CSAT
Center for Substance Abuse Treatment
SAMHSA

Dedication

This monograph is dedicated
to those who are stepping out of the shadows
to put a face and voice
on medication-assisted recovery.

Table of Contents

Foreword by H. Westley Clark ..... **v**
Preface by Michael T. Flaherty, Lonnetta Albright, and Arthur C. Evans, Jr. ..... **vi**
Acknowledgements ..... **viii**
Executive Summary **1**
Introduction
Summary of Key Points, I: Historical Context 2
Summary of Key Points, II: Recovery and Methadone 4
Summary of Key Points, III: A Vision Statement 6
Summary of Key Points, IV: Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia 10
A Brief Note on Language 13
I. Historical Context **14**
Medication and Chronic Diseases 15
The History of Methadone Maintenance 16
Opioid Addiction Treatment Before Methadone Maintenance 17
The Context for Methadone Maintenance 18
The Birth and Early Refinement of Methadone Maintenance as a Model Treatment 19
Early Theoretical Foundation for Clinical Practices 21
Early Challenges 26
Early Recovery Orientation of MM 27
Funding, Diffusion, and Regulation of Methadone Maintenance 29
Changing Clinical Practices in MM in the 1970s and 1980s 31
Early Methadone Critics 36
Toward the Revitalization and Elevation of Methadone Maintenance 38
Recent Growth of Methadone Maintenance 40
The Quality of Methadone Maintenance 40
Cultural and Professional Status of Methadone Maintenance 41
Recovery-oriented Methadone Maintenance 42
Summary 46
II. Recovery and Methadone **47**
Methadone and Recovery Status 48
Recovery as Intention 48
Recovery as Remission 49
Recovery as Abstinence 51
Recovery as Global Health and Functioning 55
The Ambiguous Identity of the MM Patient 59
The Question of Family Recovery 60
Summary 62

III. A Vision Statement **65**
The Management of Chronic Disease 67
Methadone Maintenance and Recovery Management 68
Attraction, Access, and Early Engagement/Retention 69
Assessment and Service Planning 76
Composition of the Service Team 77
The Service Relationship 80
Service Quality/Duration 84
Dosing Philosophy/Protocol 84
Addiction Counseling 86
Scope of Ancillary Services 90
Service Duration 92
Discharge Status and Recovery Outcomes 97
The MM Milieu: Culture of Addiction or Culture of Recovery? 99
The Locus of Service Delivery 100
Assertive Linkage to Recovery Community Resources 101
Post-Treatment Recovery Checkups, Stage-Appropriate Recovery Education and Support, and, When Needed, Early Re-Intervention 103
Recovery-oriented Methadone Maintenance: Further Reflections on Outcome Measures 105
A Brief Note on Evidence-Based Practices in ROMM 107
Summary 107
IV. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia 112
Introduction 112
Stigma Basics 113
Historical/Sociological Perspectives 123
Conceptual Underpinnings of MAT-Linked Stigma 130
Table 1: Stigma-Linked Beliefs and Their Scientific Status 130
Semantic and Visual Images Underpinning MAT-Related Stigma 132
Street Myths and Stigma 133
Table 2: Myths and Facts 134
Examples of Addiction/Treatment/Recovery-Related Stigma/Discrimination 137
Conceptual Underpinnings of a Campaign to Eliminate Stigma Related to Methadone 139
The Nature of Addictive Disorders 140
Nature of Addiction Recovery 141
Medication and Recovery 142
Stigma as a Barrier to Recovery 144
An Addiction/Treatment/Recovery Campaign 144
Recovery Representation and Community Mobilization 145

Community Education 146
Professional Education 147
Non-Stigmatizing, Recovery-Focused Language 148
Treatment Practices 149
Local, State, and Federal Policy Advocacy 150
Evaluation 151
Summary 151
About the Authors 152

Foreword

During its long history, Methadone Maintenance has struggled with a reputation that conjures images of seedy Methadone clinics in rundown neighborhoods, inhabited by drug users who are merely substituting one drug for another. The emphasis seemed to be on "maintenance" rather than "treatment."

Meanwhile, the substance abuse treatment field began to evolve, recognizing that substance use disorders are diseases that respond to treatment that can lead to recovery. The focus shifted to defining exactly what was needed to support recovery, and the idea of a more holistic approach began to take shape.

This recovery-oriented systems approach acknowledges the importance of a person-centered, community-involved recovery process–ideas that had not previously been associated with Methadone Maintenance. The question is why not?

Recovery-oriented Methadone Maintenance answers that question by presenting a dynamic and convincing picture of how recovery-oriented systems can be applied to Methadone Maintenance, bringing it into the recovery process. In doing so, the stigma that has surrounded Methadone Maintenance for much of its life is replaced by the recognition that Methadone has a legitimate place within the recovery-oriented system.

When brought into the recovery process, the benefits of Methadone Maintenance are enhanced through linkages with other communities, resources, and systems. Methadone becomes part of the client's recovery, rather than being perceived as a crutch. Through the integration of the recovery-oriented approach the Methadone Maintenance client becomes empowered to affect his or her recovery. The provider begins to treat the entire person, not just the addiction. The result is better and more accurate treatment management and reduced misuse and abuse.

The challenge becomes communicating this new approach to the Methadone Maintenance community. *Recovery-oriented Methadone Maintenance* meets that challenge, establishing an appropriate place for Methadone Maintenance within the recovery community. It is a volume that should be absorbed by medication-assisted treatment providers, whether or not they are currently involved in Methadone Maintenance, as well as all treatment providers. It is time to overcome the stigma associated with Methadone and focus on recovery. It is time to recognize that each person's path to recovery is different and that Methadone Maintenance can and does have a legitimate place on that path for many.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director, Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health & Human Services

Preface

Sit down and be prepared to feel the earth move beneath you. For nearly half a century, methadone has been used successfully—but never without controversy—as a medication in the treatment of opioid addiction. This latest recovery monograph by William L. White and Lisa Mojer-Torres reviews the history and cultural context of methadone maintenance (MM) treatment in the United States, with an emphasis on the evolution of practices that directly influence long-term recovery outcomes. These pages offer a distinct understanding of medication-assisted recovery in general, and methadone-assisted recovery in particular. On page 7, the authors write:

> *Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—what we here refer to as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery support resources).*

Too much to ask, one might say? Actually, not at all. It's just the beginning. In this new recovery-focused understanding, methadone maintenance is saved from being an end in itself and is instead portrayed as a medication that, when wrapped in an array of professional and peer-based support services, will offer many individuals their best opportunity for long-term recovery. Because it is recovery-focused and measured by more than drug stabilization, Recovery Oriented Methadone Maintenance (ROMM) becomes simultaneously an enhancement to medication maintenance alone, a defense against medication as personal pacification or social control, and a safeguard against non-rehabilitative approaches that perversely profit from the dependence of others. ROMM protects pharmacotherapy with an array of technically skilled, recovery-thinking professional and peer-based recovery supports; opportunities for family and community involvement (often absent today); and measures and accountabilities. Together, these reach into the quality and wellness of the individual's life and tie the gained recovery capital of the individual to the gained recovery capital of the community.

Most critical in this new understanding is the realization that being "in recovery" may or may not mean being on methadone. Indeed, some readers will contest or challenge this view, insisting that only by being "drug-free" and off methadone can one even begin to say, "I am in recovery." The authors chart the historical sources of that view, but herein advance that being on properly monitored methadone is really no different from being on other medications (e.g., insulin for diabetics, antidepressants for depression, disulfirum for alcoholism, etc.) that support one's recovery from other chronic illnesses. In this view, the MM patient attains recovery when he or she engages in a process of recovery that:

- leads to stabilization on his or her optimal dose,
- helps the patient abstain from the use of alcohol and other intoxicating drugs, and
- produces evidence of improved global health and social functioning.

As the authors contend, it is time that MM patients who meet this three-part definition of recovery are welcomed into American communities of recovery. It is also time that recovery from opioid dependence was recognized as more than the removal of drug use from an otherwise unchanged life.

Perhaps the most important insights are related to the entwining of the social contexts and historical influences that the authors illuminate. White, a world leader in recovery-focused historical research and advocacy, and Mojer-Torres, an eminent lawyer and advocate for people involved in MM treatment, speak for the person and family first. In speaking of the quality of methadone

services and its cultural and professional status today, the authors open new frontiers by traversing across time to present-day criticisms of MM, and delineate what ROMM in particular can do to help us transcend those concerns. In this, providers are asked to "go the distance" by adding a recovery focus, staff in recovery (with or without MM), recovery representation on their boards of directors, program recovery philosophy, and recovery-focused and -measured care. Regulators are directly challenged to ameliorate the overwhelming barriers to achieving a more humane, sensitive, and potentially effective system of opioid dependence treatment. Even the traditional role of MM dispensed only via Opioid Treatment Programs (OTPs) is challenged by the advocacy of office-based care for those well into recovery but still in need of methadone-assisted physical stabilization. The monograph concludes with a paper describing recovery in the city of Philadelphia that offers priceless added understanding of ways of recognizing, addressing, and reducing stigma in this population. This one is a classic in and of itself.

Indeed, by now, if you are still in your chair, you have felt the earth move. William White and Lisa Mojer-Torres offer a new view, one which must be considered fully and which we as publishers believe will ultimately elevate and advance the quality of methadone treatment in the United States.

Read on, dear reader, travel this monograph with its sweeping review of the history of MM, reframed and elevated today within a recovery focus and framework. You will hear much in this work from these two long-term recovery advocates, from other experts and critics, and from other voices in recovery—with and without current methadone assistance—who share their personal experience and insight. The articles, each also available as a stand-alone for separate use and publication, will stir thought and discussion, but they will also suggest that we do much more in implementation, if we are to evolve and individuals and communities are to find ROMM. Many examples are provided, and clinicians, seasoned addiction experts, and methadone practitioners are asked to take the next step—instilling and sustaining a recovery focus in treatment—that will restore purpose and invigorate the desire to treat the person and the addiction in general, rather than just treating addiction with a particular drug or defining a person by a particular medication.

In the end, we believe we are all enhanced by this work: authoritative, experiential, novel, and yet sensible—very sensible. Recovery, defined for medication-assisted treatments and methadone maintenance in particular, re-asserts a clear purpose and measurable and accountable outcomes. These pages offer hope that we can connect professionally directed biopsychosocial intervention to the process of long-term, self-maintained recovery.

Michael T. Flaherty, PhD
Principal Investigator
Northeast ATTC

Lonnetta Albright
Executive Director
Great Lakes ATTC

Arthur C. Evans, PhD
Director
Philadelphia DBHMRS

Publishers' Note: This latest monograph represents the seventh in a series of monographs by William White and co-authors, a series that explores the evolving understanding of addiction as a chronic illness best addressed through a focus on its recovery and on those seeking or in recovery. All have been published by the Great Lakes Addiction Technology Transfer Center (ATTC), the Northeast Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health and Mental Retardation Services. The publishers wish to gratefully acknowledge the SAMHSA Center for Substance Abuse Treatment for the support that makes this work possible, and to acknowledge our respective ATTC parent organizations: the University of Illinois – Chicago (UIC) and the Institute for Resarch, Education and Training in the Addictions (IRETA). In these publications we seek, not to be clinically proscriptive, but to challenge through insight and experience, so as to build from these works an even greater world of possibility for improved care and more effective and fulfilling recovery. The monographs are available for free viewing or download at www.williamwhitepapers.com, www.ireta.org, and www.attcnetwork.org/greatlakes.

Acknowledgements

The authors would first like to thank the many current and former methadone patients for their contributions to this monograph. The experiences you shared with us were crucial to the vision of medication-assisted recovery presented in this monograph.

Support for this monograph was provided by the following organizations: the Great Lakes Addiction Technology Transfer Center and the Northeast Addiction Technology Transfer Center (funded by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment) and the Philadelpha Department of Behavioral Health and Mental Retardation Services. The opinions expressed in this monograph are those of the authors and do not necessarily reflect the positions of these organizations.

The authors are also indebted to the following individuals for providing critical information, thoughtful discussion, comments and suggestions, or technical assistance in the preparation of this series of papers: Lonnetta Albright, Sadé Ali, Stephen Bamber, David Best, PhD, John T. Carroll, Bob DuPont, MD, Arthur Evans, Jr., PhD, Mike Flaherty, PhD, Tyrone Frazier, Rod Funk, Walter Ginter, Robert Holmes, Jerome Jaffe, MD, Herman Joseph, PhD, Scott Kellogg, PhD, Karol Kaltenbach, PhD, Gregg Kelinson, Herbert Kleber, MD, Mary Jeanne Kreek, MD, Roland Lamb, Alexandre Laudet, PhD, Marvin Levine, Ira Marion, Denise McCulley, J. Bryce McLaulin, MD, Terence McSherry, Stephanie Merkle, Charles Morgan, MD, Robert Newman, MD, Mark Parrino, Thomas Payte, MD, Constance Pechura, PhD, Paul Poplawski, Jason Schwartz, Ed Senay, MD, Bob Stringer, Pat Taylor, Stephen Weinstein, PhD, Pamela Woll, Joycelyn Woods, and Joan Zweben, PhD. Special thanks to the Philadelphia Medication-assisted Treatment Providers for their many helpful suggestions, and to J. Bryce McLaulin, MD and Charles Morgan, MD for early discussions that inspired this monograph.

Regarding the fourth article on stigma attached to medication-assisted treatment and recovery, additional thanks are due to Dr. Herman Joseph for his landmark dissertation on methadone-related stigma and for the insights he provided in interviews with the author. A portion of the literature review presented in this fourth article was published as: White, W., Evans, A., & Lamb, R. (2009). Stigma: The addictions professional as activist. *Counselor,10*(6), 52-58.

Executive Summary

There are growing calls to shift the acute-care model of addiction treatment to a model of sustained recovery support analogous to the long-term management of other chronic diseases. The purpose of this monograph is to explore what this shift means to the design and delivery of methadone maintenance (MM) treatment and the status of MM treatment and MM patients in the United States.

Recovery-oriented Methadone Maintenance has two primary audiences. For addiction treatment professionals and recovery support specialists who have not worked in methadone maintenance treatment, our goals are to:

- provide a primer on the historical evolution and scientific status of MM treatment,
- explore the controversies surrounding recovery status and methadone maintenance, and
- enlist readers' support for a model of recovery-oriented methadone maintenance (ROMM).

For addiction treatment professionals, recovery support specialists, and patients and their families directly involved with MM treatment, our goals are to:

- document the dissipation of recovery orientation within the evolution of MM treatment,
- engage readers' support in reviving and extending such a recovery orientation,
- discuss MM in the context of recent efforts to define and measure addiction recovery,
- describe core clinical practices within MM that would change in the shift toward a model of ROMM, and
- outline strategies to address the professional and social stigma attached to methadone, MM treatment, and MM patients.

Recovery-oriented Methadone Maintenance is divided into four articles:

I. Historical Context

II. Recovery and Methadone

III. A Vision Statement

IV. Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia

These four articles are also available individually, each containing both the relevant Executive Summary material and the content from the body of the monograph. The intent is to provide tools for both broad and focused examinations of this critical topic.

Introduction

William L. White, MA
Lisa Mojer-Torres, JD

Summary of Key Points — I: Historical Context

Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines methadone pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—recovery defined here as remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration.

DISTINCTIVENESS OF ROMM

ROMM provides an alternative to acute care (heroin detoxification or short-term maintenance) and palliative care (medication maintenance as a strategy of personal pacification and social control). ROMM is a person-centered model of long-term recovery management.

OPIOID ADDICTION AS A CHRONIC DISEASE

It was the dream of those who developed methadone maintenance that chronic opioid addiction would one day be addressed with the same treatment philosophies and strategies used to manage other chronic medical disorders. Within this framework, the methadone maintenance patient is viewed on par with patients requiring normalizing doses of insulin, anti-convulsive medication, or hypertensive medication and psychosocial support services. Fulfillment of that vision has been thwarted by the strong anti-medication bias that pervades the history of addiction treatment and recovery in the United States.

EARLY TREATMENT HISTORY

The treatment of opioid addiction in the United States spans nineteenth-century institutional treatment (inebriate homes, inebriate asylums, and private addiction cure institutes); detoxification by private physicians; exotic and sometimes lethal medical withdrawal procedures; fraudulent proprietary home cures; early twentieth-century morphine maintenance clinics; mid-twentieth-century prison-based treatment ("narcotics farms"); and experiments with aversive conditioning, electroconvulsive treatments, psychosurgery, and psychoanalysis. All were characterized by high rates of resumed opioid addiction following treatment cessation.

THE CONTEXT FOR METHADONE TREATMENT

Methadone maintenance was pioneered in the mid-1960s in the wake of a dramatic rise in heroin addiction following the Second World War. Therapeutic pessimism regarding traditional approaches to treatment prompted calls by major policy bodies for new experiments in the maintenance of persons chronically addicted to heroin. Methadone maintenance developed amidst competing approaches to this problem: mass incarceration, Narcotics Anonymous, ex-addict-directed therapeutic communities, hospital-based detoxification, alternative pharmacotherapies, experiments with civil commitment, and faith-based outpatient counseling clinics.

THE ORIGIN OF METHADONE MAINTENANCE

Methadone maintenance (MM) was pioneered in 1964 by Dr. Vincent Dole, Dr. Marie Nyswander, and Dr. Mary Jeanne Kreek at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital. Following early studies on its safety and effectiveness, MM was

integrated into multi-modality treatment systems in New York, Illinois, Connecticut, Massachusetts, Pennsylvania, and Washington, D.C. and then more widely disseminated in the 1970s within a growing national network of addiction treatment programs in the United States.

EARLY THEORETICAL FOUNDATIONS

MM was based on a metabolic theory of addiction that viewed heroin addiction as a genetically influenced, chronic brain disease requiring sustained medical management—a problem of sickness rather than sinfulness. Metabolic stabilization and maintenance (via individualized, optimal daily oral doses of methadone) were viewed as essential for most patients to achieve successful long-term recovery. MM was defined as "corrective but not curative." It was believed that many, if not most, MM patients would require prolonged if not lifelong pharmacotherapy to sustain their recoveries. In the early-stage theory of MM treatment, biological stabilization was expected to be followed by psychosocial rehabilitation and community reintegration—processes requiring a broad menu of ancillary services and supports.

EARLY RECOVERY ORIENTATION

Recovery-oriented practices (those now known to be linked to elevated long-term recovery outcomes) within the early MM model included: 1) rapid access to treatment in early sites (e.g., New York City, Washington, D.C.); 2) patient involvement in clinical decision-making; 3) methadone doses (usually 80-120 mgd with no dose ceilings) capable of suppressing withdrawal distress, reducing craving, and inducing a "blockade effect" to other opioids; 4) therapeutic responses to any continued drug use; 5) a chronic care perspective that placed no arbitrary limits on duration of MM participation; 6) emphasis on creating a strong therapeutic alliance with each patient; 7) use of recovering staff as role models; 8) development of programs for populations with special needs; and 9) the broader mobilization of community resources to respond to addiction, including long-term recovery support needs.

DIFFUSION OF MM

Public and political alarm about heroin-related crime and about heroin use by U.S. soldiers in Vietnam spurred federal investment in addiction treatment and the subsequent diffusion of methadone maintenance in the United States. The number of methadone patients in the U.S. grew from fewer than 400 patients in 1968 to more than 80,000 patients in 1976, with much of that expansion occurring in New York City.

DECREASED RECOVERY ORIENTATION

The regulation and mass diffusion of MM in the 1970s and 1980s was accompanied by changes in treatment philosophy and clinical protocols. The most significant of these changes in terms of recovery orientation included a shift in emphasis from personal recovery to reduction of social harm; increased preoccupation with regulatory compliance; widening variation in the quality of MM programs; the reduction of average methadone doses to subtherapeutic levels; arbitrary limits on the length of MM treatment; pressure on patients to taper and end MM treatment; the erosion of ancillary medical, psychiatric, and social services; and a decreased emphasis on therapeutic alliance between MM staff and MM patients. The definition of *recovery* during this period shifted from a focus on global health and functioning to an almost exclusive preoccupation with abstinence—then defined as including cessation of methadone pharmacotherapy. The public face of MM became defined by the worst MM clinics and the least stabilized MM patients. Professional, political, and public support for MM as a medical treatment for opioid addiction declined through the late 1970s and early 1980s until the value of MM was revived in the late 1980s as a public health strategy to address the spread of HIV/AIDS. In spite of these challenges, many MM treatment staff continued to promote a vision of recovery, and many MM patients achieved but were forced to hide their achievement of that vision to avoid the social and professional stigma attached to MM.

METHADONE CRITICS

The inevitable backlash to early media reports of methadone as a miracle cure for heroin addiction spawned numerous critics of methadone maintenance treatment. Critics of medication-assisted treatment, many of whom were competing for cultural and economic ownership of the problem of heroin addiction, alleged that MM: 1) substitutes one drug/addiction for another; 2) conveys a societal attitude of permissiveness toward drug use; 3) fails to address the characterological or social roots of heroin addiction; 4) cognitively, emotionally, and behaviorally impairs MM patients; 5) is a tool of racial oppression and genocide; 6) is financially exploitive; and 7) as a result of these factors, is morally unacceptable.

THE REVITALIZATION OF MM

Since the early 1990s, there has been a revitalization of MM in the United States. This process has included: 1) the scientific reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies; 2) increased advocacy efforts by MM patients; 3) an expansion of national MM treatment capacity—most notably within the private sector; 4) national efforts to professionalize and elevate the quality of newly rechristened and accredited Opioid Treatment Programs (OTPs); and 5) an expansion of pharmacotherapy choices in the treatment of opioid addiction, e.g., buprenorphine/Suboxone/Subutex. These developments occurred amidst renewed efforts to publicly and professionally portray opioid addiction as a brain disease that can be medically managed with the aid of methadone and other pharmacotherapies. In spite of such advancements, resistance and hostility toward methadone continue from many quarters.

RECOVERY-ORIENTED METHADONE MAINTENANCE

Two trends are reshaping the future of MM in the United States: 1) a clearer articulation of addiction as a chronic disorder that is best treated through methods used to manage other chronic disorders, and 2) the emergence of recovery as an organizing paradigm for the addictions field. If sustained, these trends will profoundly change the nature of all addiction treatment, including MM treatment.

THE FUTURE OF MM

The future of MM in the United States rests on the collective ability of OTPs to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of public education and political/professional influence. It also rests on the mobilization of a grassroots advocacy movement of MM patients and their families. An important next step in the developmental history of MM is to define recovery within the context of methadone maintenance and within the broader pharmacotherapeutic treatment of substance use disorders.

Summary of Key Points — II: Recovery And Methadone

DEFINING RECOVERY WITHIN THE CONTEXT OF MM

Controversy and stigma continue to surround the use of methadone maintenance as a medical treatment of opioid addiction, in spite of more than four decades' worth of scientific evidence of its effectiveness. Methadone patients continue to be socially marginalized, and their recovery status continues to be debated—even within the professional field of addiction treatment and within communities of recovery. The question of the recovery status of methadone patients cannot be answered without a clear understanding of what constitutes recovery from opioid addiction. The definition of recovery applied to the patient in medication-assisted recovery from opioid addiction should be the same as that applied to recovery from any other substance use disorder.

RECOVERY AS MORE THAN INTENT

Recovery from opioid addiction is more than exhibiting motivation to stop or decelerate drug use. Defining recovery in terms of "he/she is trying" sets a low bar for expectations related to the methadone maintenance patient's health, functioning, and quality of life. Defining recovery only as a motivational state also contributes to the professional and social stigma attached to methadone, MM treatment, and the MM patient and inhibits MM patients' positive reintegration into the community.

RECOVERY AS MORE THAN REMISSION

Recovery from opioid addiction is also more than remission, with remission defined as the sustained cessation or deceleration of opioid and other drug use/problems to a subclinical level—no longer meeting diagnostic criteria for opioid dependence or another substance use disorder. Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community.

CORE ELEMENTS OF RECOVERY

Recent attempts to define addiction recovery (e.g., Betty Ford Institute Consensus Conference, CSAT Recovery Summit, United Kingdom Drug Policy Commission) have focused on three essential elements: a) the resolution of drug-related problems (most often measured in terms of sobriety/abstinence or diagnostic remission), b) improvement in global health, and c) citizenship (positive community re-integration).

METHADONE AND RECOVERY

There is growing professional consensus that the stabilized methadone maintenance patient who does not use alcohol or illicit drugs, and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners, meets the first criterion for recovery. MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the use of methadone as a medication. For the stabilized MM patient, methadone is NOT a substitute for heroin: the motivations for, effects of, and cultural symbolism of using methadone as a medication are vastly different from those associated with heroin use.

DISTINGUISHING PHYSICAL DEPENDENCE FROM ADDICTION

Physical dependence and addiction are not the same: the stabilized methadone maintenance patient—here defined as the patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners—does not, like many pain patients maintained on opioid medications, meet key definitional criteria for addiction (e.g., obsession with using, loss of volitional control over use, self-accelerating patterns of use, compulsive use in spite of escalating consequences).

RECOVERY STATUS OF THE MM PATIENT

Denying "abstinence" or "drug free" status to stabilized MM patients (who do not use alcohol or illicit drugs and who take methadone and other prescribed drugs only as indicated by competent medical practitioners) based solely on their status as methadone patients inhibits rather than supports their long-term recoveries.

VARIETIES OF MEDICATION-ASSISTED RECOVERY

For stabilized MM patients, continued methadone maintenance or completed tapering and sustained recovery without medication support represent varieties/styles of recovery experience and matters of personal choice, not the boundary between and point of passage from the status of addiction to the status of recovery.

MM PATIENT AND COMMUNITIES OF RECOVERY

The stabilized MM patient is caught in an ambiguous world—separated from cultures of active drug use, denied full membership in cultures of recovery, and socially stigmatized in the larger community. It is time for recovering MM patients to be welcomed into full membership in the culture of recovery and afforded opportunities to pursue full citizenship in their local communities.

FAMILY RECOVERY IN THE MM CONTEXT

Rarely has the concept of recovery been applied to the families of MM patients. Opioid addiction severely wounds family and kinship relationships—wounds that feed the intergenerational transmission of drug-related problems. Family recovery involves healing those wounds; reconstructing family roles, rules, and relationships; and enhancing the resistance/resilience/health of all family members. The ultimate aim of family recovery is breaking the intergenerational transmission of drug-related problems.

SEEKING A VANGUARD OF MM PATIENTS

It is unlikely that the recovery status of the MM patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MM patients and their families stand together to offer living proof of the role methadone can play in long-term recovery from opioid addiction. The faces and voices of healthy, fully functioning MM patients will be the most powerful antidotes to the stigma attached to opioid addiction and methadone maintenance treatment.

MULTIPLE PATHWAYS OF RECOVERY

There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering. Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or buprenorphine/Suboxone/Subutex) represent personal styles of recovery and should not be framed in categories of superiority or inferiority, right or wrong, or recovery inclusion or recovery exclusion. Rather than a source of disqualification from recovery status, methadone, provided as a medication under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized.

RECOVERY DEFINITION AND THE DESIGN OF OPIOID TREATMENT PROGRAMS

Achieving this vision of recovery as remission, global health, and citizenship for the mass of MM patients will require expanding and elevating the range and quality of clinical and peer-based recovery support services available to MM patients and their families. It will also require creating the physical, psychological, and cultural space in local communities within which medication-assisted recovery can flourish.

Summary of Key Points — III: A Vision Statement

THE MANAGEMENT OF CHRONIC DISEASE

Addiction to heroin or other short-acting exogenous opioids shares many of the characteristics of other chronic illnesses. Principles and practices that characterize the effective management of other chronic primary diseases can be adapted to effectively manage and improve long-term recovery outcomes in the treatment of chronic opioid addiction.

METHADONE MAINTENANCE AND RECOVERY MANAGEMENT

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—referred to here as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery support resources). Eight arenas of service practice will be profoundly transformed in the move toward ROMM: 1) attraction, access, and early engagement; 2) assessment and service planning; 3) service team composition; 4) service relationships; 5) service quality and duration; 6) locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term recovery check-ups, stage-appropriate recovery support, and, when needed, early re-intervention.

ATTRACTION, ACCESS, AND EARLY ENGAGEMENT/RETENTION

Methadone maintenance treatment attracts voluntary participation by more people addicted to heroin and other short-acting opioids than any other addiction treatment modality, but most people in need of treatment for opioid addiction are not currently in treatment, will seek treatment only at late stages of their addictions, will drop out of treatment before optimum therapeutic effects are achieved, and will experience prolonged addiction/treatment careers before recovery stability is achieved. A key strategy of ROMM is to attract, engage, and retain patients at the earliest stages of problem development, toward the twin goals of shortening addiction careers and extending recovery careers. Promising practices in enhancing treatment attraction include educational campaigns to reach injection drug users, designed to dispel myths and misconceptions about MM treatment, and assertive community outreach teams that provide visible role models of medication-assisted recovery, engage active users in a “recovery priming” process, mobilize family and kinship support, and resolve obstacles to treatment participation. Access to MM could be increased via expanded public and private funding of MM treatment, distribution of coupons for free treatment, reduction of regulatory obstacles that inhibit rapid access, expedited admission (e.g., interim maintenance—methadone without counseling), and moving stabilized patients to medical maintenance (methadone provided by trained primary care physicians). Promising practices related to engagement and retention in MM include individualized and higher methadone doses (above 60 mgd), increased patient choices, telephone and email prompts following missed appointments, patient education related to the safety and benefits of MM, provision of sustained peer-based recovery coaching, and provision of mental health services for co-occurring mental illness.

ASSESSMENT AND SERVICE PLANNING

Practices aimed at increasing the recovery orientation of the assessment and service planning process within MM treatment include shifting from categorical to global assessment instruments and interview protocols; defining the family (as defined by the patient) rather than the individual as the unit of service; using a strengths-based assessment process to identify personal, family, and community/cultural assets that can be mobilized to support recovery initiation and maintenance; viewing assessment as a continual rather than a single-point-in-time intake process (based on the understanding that service needs change across the developmental stages of recovery); and transitioning from professionally directed treatment plans to patient-directed recovery plans.

COMPOSITION OF THE SERVICE TEAM

Treatment of chronic diseases, in contrast with the treatment of acute disease or trauma, involves a broader multidisciplinary team and a greater emphasis on peer support for long-term recovery management. Implementing models of ROMM will involve key staffing changes within OTP programs, including a greater role of addiction medicine specialists in patient/family/community education; increased involvement of primary care physicians; co-location of OTPs and primary health care clinics; greater inclusion of family/child therapists; increased use of current and former

patients in medication-assisted recovery as staff and volunteers; and the use of indigenous healers drawn from diverse cultural communities, e.g., leaders of recovery-focused religious and cultural revitalization movements.

THE SERVICE RELATIONSHIP

Service relationships within chronic disease management are distinctive in their duration (measured in years or decades), the degree of intimacy that develops between the service providers and the patient and family, and the broader focus of the relationship—the global health and functioning of the patient and family rather than treatment of a particular health defect. Positive indicators of recovery-oriented service relationships include increased levels of recovery representation at OTP governance, leadership, and service delivery levels; respect for patient opinions and preferences via a choice philosophy; changes in administrative discharge policies; reduced incidence of administrative discharges and other premature disengagements from service; elevating patients' hopes and possibilities; transitioning patients from professionally directed treatment plans to patient-directed recovery plans; and an emphasis on sustained continuity of contact and support across the stages of long-term recovery.

SERVICE QUALITY/DURATION

ROMM involves ensuring six critical areas of service practice: 1) dosing policies that ensure safe induction (optimum, individualized, and effective dose stabilization); 2) addiction counseling that is focused on building and sustaining a recovery process/partnership rather than the mechanics of dosing or service contact documentation; 3) expanding ancillary resources to address co-occurring medical, psychiatric, and other substance-related problems; vocational/employment/education needs; need for peer-based recovery support; and the needs of patients' families/children; 4) ensuring an adequate period of dose stabilization and psychosocial rehabilitation before any efforts to taper from MM (at least 1-2 years to achieve the best long-term recovery outcomes) and offering increased supports during and following the cessation of methadone maintenance; 5) increasing the percentage of MM patients who successfully complete treatment; and 6) building a strong culture of recovery within the MM service milieu.

THE LOCUS OF SERVICE DELIVERY

ROMM anticipates a greater focus on delivery of recovery support services outside the clinic and the greater integration of medication and other recovery support services within non-stigmatized community environments. Promising practices in this area include shifting from siloed OTPs toward the integration of MM within comprehensive addiction treatment and recovery support centers, the expansion of office-based treatment and medical maintenance, and greater use of neighborhood- and home-based recovery support services. The focus of ROMM is on firmly nesting recovery within the natural environment of each patient or in helping develop an alternative environment in which long-term recovery can be nurtured.

ASSERTIVE LINKAGE TO RECOVERY COMMUNITY RESOURCES

Peer-based recovery support resources are growing rapidly in the United States via the expanding network of addiction recovery mutual aid groups, the philosophical diversification of these groups, the emergence of a new addiction recovery advocacy movement, new recovery community institutions, and the emergence of new peer-based service roles (e.g., the recovery coach). Promising practices for ROMM in this area include:

- active liaison between OTPs and the service committees of local recovery mutual aid societies;
- encouraging/supporting the development of groups specifically for persons in medication-assisted recovery and assertive linkage of patients to the resources of local communities of recovery (including medication-friendly recovery support meetings);

- using volunteer or paid peer recovery coaches to facilitate patient connections to recovery community resources, coaching patients on ways of addressing medication issues at recovery support meetings, and hosting onsite peer recovery support meetings at or near OTPs;
- sponsoring educational events on medication-assisted recovery for recovery community members;
- inclusion of indigenous healers and healing practices within OTPs;
- using patient/alumni councils to visibly celebrate patient recovery milestones; and
- visibly participating (OTP staff and MM patients/families) in local recovery celebration events.

LONG-TERM RECOVERY CHECK-UPS; STAGE-APPROPRIATE RECOVERY EDUCATION AND SUPPORT; AND, WHEN NEEDED, EARLY RE-INTERVENTION

Most people addicted to opioids experience prolonged addiction careers marked by cycles of treatment, periods of abstinence, resumption of opioid addiction, and treatment re-entry. Assertive approaches to in-treatment and post-treatment monitoring significantly enhance long-term recovery outcomes. We envision a future in which a system of recovery check-ups, peer-based recovery support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention will reduce post-treatment mortality and enhance the long-term recovery outcomes of MM patients.

SUMMARY

Put simply, ROMM seeks to:

- **attract** people at an earlier stage of problem development via programs of assertive community education, screening, and outreach;
- **ensure rapid service access** for individuals and families seeking help;
- **resolve obstacles** to initial and continued treatment participation;
- **achieve safe, individualized, optimum dose stabilization;**
- **engage and retain** individuals and families in a sustained recovery-focused service and support process;
- **assess patient/family** needs using assessment protocols that are global, family-centered, strengths-based, and continual;
- **transition each patient** from a professionally directed treatment plan to a patient-directed recovery plan;
- **expand the service team** to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;
- **shift the service relationship** from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
- **ensure minimum (at least one year) and optimum (individualized) duration of treatment** via focused retention strategies and assertive responses to early signs of disengagement;
- **shift the treatment focus** from an episode of care to the management of long-term addiction/treatment/recovery careers;
- **expand the service menu** to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;
- **extend the locus of service delivery** beyond the OTP to non-stigmatized service sites and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;

- **assertively link patients/families** to recovery community support resources;
- **engage the community** through anti-stigma campaigns and recovery community development activities;
- **provide post-treatment monitoring and support and stage-appropriate education, support, and (if and when needed), early re-intervention** for all patients regardless of discharge status; and
- **evaluate MM treatment** using proximal and distal indicators of long-term personal and family recovery.

Care will need to be taken to avoid potential unintended consequences of this heightened recovery orientation, e.g., the abandonment of patients who do not share this vision of a recovery-transformed life.

Summary of Key Points — IV: Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery Within the City of Philadelphia

INTRODUCTION

This article, developed for the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS): 1) reviews the historical and scientific research on the social/professional stigma related to addiction, with a particular focus on the stigma experienced by people in medication-assisted recovery; and 2) outlines strategies that could be used by DBHMRS and its many community partners to reduce addiction/recovery-related stigma.

STIGMA BASICS

Research on the social stigma related to addiction can be summarized briefly as follows.

- Stigma involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion, as well as the internalization of community attitudes in the form of shame by the person/family being discredited.
- The social stigma attached to addiction constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the type and magnitude of cultural resources allocated to alcohol- and other drug-related problems.
- Social stigma attached to addiction is influenced by perceptions of the role of choice versus compulsion in addiction, the motivation for initial drug use (a search for pleasure versus escape from pain), and whether addiction is related to a socially defined “good” or “bad” drug.
- The social stigma attached to addiction is greatest for those experiencing multiple discrediting conditions, e.g., combinations of addiction, psychiatric illness, HIV/AIDS, minority status, poverty, homelessness, and the perception that a woman has failed to meet her gender-role expectations due to addiction.
- Addiction-related social stigma elicits social isolation, reduces help-seeking, and compromises long-term physical and mental health outcomes of those with severe alcohol and other drug problems.
- Heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution for nearly a century.

- Methadone maintenance has never achieved full legitimacy as a medical treatment by the public, health care professionals, and the recovery community, in spite of the overwhelming body of scientific evidence supporting its effectiveness.
- The person enrolled in methadone maintenance has never received full status as a "patient," and the methadone clinic has yet to be viewed as a place of healing on a par with hospitals or outpatient medical clinics.
- The professional status of methadone treatment has suffered from the absence of theoretical models of treatment and recovery that transcend a focus on the medication to address the larger movement toward global health and community integration.
- Personal strategies to deal with stigma include secrecy/concealment, social withdrawal, selective disclosure, over-compensation in other areas, and political activism.
- Three broad social strategies have been used to address stigma related to behavioral health disorders: 1) personal or mass protest (advocacy), 2) public and professional education, and 3) strategies that increase interpersonal contact between stigmatized and non-stigmatized groups.

HISTORICAL/SOCIOLOGICAL PERSPECTIVES

The social stigma attached to certain patterns of psychoactive drug use has a long history in the United States and is inseparable from cultural strain related to such issues as race/ethnicity, religion, social class, gender roles, and intergenerational conflict. The social stigma attached to methadone is rooted in a larger anti-medication bias within the history of addiction treatment. Social stigma toward alcohol and other drug (AOD) addiction may be defined as a negative social force (an obstacle to problem resolution) or as a positive social force (discouragement of drug use; social pressure for help-seeking). A key question for local communities is: how do addiction treatment professionals, recovery advocates, and preventionists avoid working at cross-purposes in their educational efforts in local communities? Any campaign to counter addiction/treatment/recovery-related stigma must ask two related questions: 1) "What is the source of stigma?" and 2) "Who profits from stigma?"

CONCEPTUAL UNDERPINNINGS OF THE SOCIAL STIGMA ATTACHED TO MEDICATION-ASSISTED TREATMENT (MAT)

Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs. These assumptions and beliefs include the following: 1) excessive drug use is a choice, 2) methadone is a "crutch," 3) methadone simply replaces one drug/addiction for another, 4) methadone prolongs rather than shortens addiction careers, 5) low doses and short periods of methadone maintenance result in better rates of long-term recovery, and 6) methadone maintenance patients should be encouraged to end methadone treatment as soon as possible. These propositions have been and are being challenged by a growing body of scientific research on methadone and medication-assisted treatment and recovery.

SEMANTIC AND VISUAL IMAGES UNDERPINNING MAT-RELATED STIGMA

The stigma attached to heroin addiction has been extended to methadone treatment and intensified through language and images within the professional and popular media that represent the least stabilized methadone patients and the lowest quality methadone clinics as the norm. The stigma attached to heroin addiction is internalized and results in an elaborate pecking order within the illicit heroin culture. Such pecking orders can be acted out with negative consequences within the milieu of methadone maintenance treatment. Any campaign to address the social stigma attached to medication-assisted treatment and recovery must transform the ideas, words, and images attached to this approach to treatment and this pathway of recovery.

STREET MYTHS AND STIGMA

Stigma attached to methadone maintenance treatment has been embedded within the illicit drug culture of the United States in ways that inhibit treatment seeking and contribute to early treatment termination. These myths topically span the origin of methadone, methadone's pharmacological properties and long-term effects, and the source of the proliferation of methadone maintenance clinics in poor communities of color. Any effective anti-stigma campaign aimed at establishing the legitimacy and effectiveness of medication-assisted treatment and recovery must include the wide and sustained dissemination of myth-challenging information within local cultures of addiction and local communities.

EXAMPLES OF ADDICTION-RELATED STIGMA/DISCRIMINATION

Addiction/treatment/recovery-related stigma manifests itself in a broad range of attitudes, behaviors, and policies that range from social shunning to discrimination, e.g., loss of access to medical/dental care, governmental benefits, training/employment opportunities, and housing and homelessness services. Stigma/discrimination related to participation in methadone maintenance includes: denial of access to methadone maintenance or medically supervised withdrawal in jail, denial of admission to other addiction treatment modalities and recovery support services, denial of pain medication, denial of the right to speak and assume leadership roles in local recovery mutual aid meetings, and loss of child custody due to participation in MMT. Stigma-influenced methadone maintenance treatment practices include arbitrary dose restrictions, restrictions on the duration of MM, lowering methadone dose as a punishment for rule infractions, disciplinary discharge for drug use, and shaming rituals (public queues to receive methadone, supervised consumption, separate bathrooms for staff and patients, observed urine drops for drug testing, discouragement of peer fraternization).

CONCEPTUAL UNDERPINNINGS OF A CAMPAIGN TO ELIMINATE STIGMA RELATED TO METHADONE

A campaign to lower stigma related to medication-assisted treatment/recovery must involve a set of messages related to the nature of addictive disorders, the nature of addiction recovery, the potential benefit of medication to the recovery process, and a statement of the harmful effects of stigma on treatment/recovery outcomes and on the family and larger community. These core ideas must be science-based, clear, capable of translation into educational slogans, and effective in altering perceptions, attitudes, and actions (as measured by pilot testing).

AN ADDICTION/TREATMENT/RECOVERY CAMPAIGN

The guiding vision of the proposed campaign is to create a city and 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."[1] The campaign goals are to: 1) enhance public and professional perceptions of the value of medication-assisted treatment, 2) enhance the perceived value of medication-assisted treatment within the heroin-using community, 3) put a face and voice on medication-assisted recovery and portray the contributions of people in medication-assisted recovery to their communities, and 4) increase the participation of medication-assisted treatment providers within local community activities. The strategies proposed for the campaign span the following areas: 1) recovery representation and community mobilization; 2) community education; 3) professional education; 4) non-stigmatizing, recovery-focused language; 5) treatment practices; 6) local, state, and national policy advocacy; and 7) campaign evaluation. The implementation of these strategies will require that people in methadone-assisted recovery take their places at the vanguard of the larger recovery advocacy movement. Efforts must be made to encourage and support that vanguard.

A Brief Note On Language

The terms *opiate* and *opioid* both appear in this monograph. *Opiate* refers to drugs derived from the poppy plant, whereas *opioid* is a more encompassing term that includes synthetic and semi-synthetic drugs. *Medication-assisted treatment* (MAT), as used in this monograph, refers to the use of medications to facilitate detoxification, suppress withdrawal symptoms, reverse cravings (normalize physiological functions), neutralize or create an aversion to the effects of particular drugs, or treat symptoms of a co-occurring medical/psychiatric disorder (normalize psychological functions). MAT is most frequently applied to the use of medications in the treatment of alcoholism (e.g., antabuse, naltrexone, nalmefene, acamprosate) and heroin addiction (e.g., methadone, buprenorphine, naltrexone). *Medication-assisted Recovery* (MAR) refers to the use of medications as an aid in recovery initiation and/or recovery maintenance. MAT refers to professional interventions; MAR refers to the activities and experience of patients whose recoveries have been supported by medications such as methadone, Buprenorphine/Suboxone, or naltrexone. *Methadone maintenance* (MM) is the use of the medication methadone in individualized, optimum doses, in tandem with counseling and other recovery support services, as a treatment for opioid addiction (primarily addiction to heroin and prescription opioids). While methadone may be prescribed by private physicians as an analgesic, MM as a treatment of opioid dependence is provided in the United States primarily by the 1,215 (as of March 5, 2010) accredited *Opioid Treatment Programs* (OTPs).[2] Patients who have achieved prolonged dose stabilization and psychosocial rehabilitation may also be eligible for *medical maintenance*—a program that allows them to see a physician once per month and receive four weeks of medication without the requirement of continued participation in an OTP. *Office Based Opioid Treatment* (OBOT) is medication-assisted treatment for opioid dependence provided in a setting other than an OTP—an option that is legal but currently limited in its availability.

1. Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma.* Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

2. N. Reuter, personal communication, March 5, 2010.

I. Historical Context

William L. White, MA
Lisa Mojer-Torres, JD

There are growing calls to shift the acute care model of addiction treatment to a model of sustained recovery support analogous to the treatment and management of other chronic diseases.[3] Efforts are underway at federal, state, and local levels to define and implement models of sustained recovery management and to nest these approaches within larger recovery-oriented systems of care.[4]

> *Recovery management (RM) is a philosophical framework for organizing addiction treatment services aimed at early pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery maintenance, and enhancement of quality of life for individuals and families affected by severe substance use disorders.*[5]
>
> *Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized 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 organization of a community, a state, or a nation.*[6]

The theoretical and scientific foundations of RM and ROSC and their implementation processes are outlined in a series of monographs developed by the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment and the Philadelphia Department of Behavioral Health and Mental Retardation Services.[7] Those seminal documents provided a vision for the future of addiction treatment and recovery support services, but they only peripherally addressed medication-assisted treatment (MAT) and, more specifically, the role of methadone maintenance (MM) in RM and ROSC.

---

3. Dennis, M. L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55. 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. Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions.* Washington, D.C.: The National Academies Press. McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-130. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

4. Halvorson, A., & Whitter, M. (2009). *Approaches to recovery-oriented systems of care at the state and local levels: Three case studies* (DHHS Publication No. (SMA) 09-4438). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. White, W. L. (2008). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care.* (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

5. 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.

6. 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.

7. Flaherty, M. (2006). *Special Report: A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery—A shift from an acute care to a sustained care recovery management model.* Pittsburgh: Institute for Research, Education and Training in Addictions. 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. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services. White, W., & Kurtz, E. (2006). *Linking addiction treatment and*

In this monograph, the authors outline a model of recovery-oriented methadone maintenance.

> *Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines medication and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery.*

ROMM provides an alternative to acute care (heroin detoxification) and palliative care (long-term medication maintenance as a form of social pacification, e.g., control of crime and disease). ROMM is a person-centered model of long-term recovery management whose primary goals are defined in terms of remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration. The ultimate aim of ROMM is an enhanced quality of life for each MM patient and his or her family, with larger social benefits viewed as flowing from this primary achievement.

This article will review the evolution of service practices within MM in the United States that have a direct relationship to long-term recovery outcomes.

MEDICATION AND CHRONIC DISEASES

Chronic diseases are distinguished by their prolonged if not lifelong course. Medications have long played a role in the stabilization and management of such disorders. Today, medications play a central role in the treatment of cancer, diabetes, thyroid disease, asthma, chronic obstructive pulmonary disease, hypertension, migraine, hemophilia, anemia, AIDS, lupus, multiple sclerosis, rheumatoid arthritis, Hepatitis C, osteoporosis, Crohn's disease, epilepsy, Alzheimer's disease, severe mental health issues, psoriasis, glaucoma, sleep disorders, and chronic pain. Medications used in the stabilization and management of chronic conditions share five defining characteristics.

1. They eliminate, reduce, or manage symptoms of the disorder but do not "cure" (permanently alter the root cause of) the disorder.
2. They "work" only as long as the medication is being consumed at optimally effective doses and frequencies.
3. Their maximum benefits are often, and to varying degrees, achieved only in tandem with changes in the patient's daily lifestyle.

---

communities of recovery: A primer for addiction counselors and recovery coaches. Pittsburgh, PA: Institute for Research, Education and Training in Addictions. White, W., Kurtz, E., & Sanders, M. (2006). *Recovery management.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

4. Recurrence of symptoms can occur even with medication adherence, most often when larger aspects of the patient's bio/psycho/social/spiritual health are disrupted.
5. When combined with broader strategies of bio/psycho/social/spiritual support, these medications can transform potentially lethal and profoundly disabling diseases into conditions that can be actively managed to sustain and enhance quality of life.[8]

It was the dream of those who developed methadone maintenance that chronic opioid addiction would one day be treated with the same philosophies and service technologies used to treat other chronic medical disorders and that the methadone maintenance patient would be viewed no differently than patients requiring daily doses of insulin, anti-convulsive medication, or hypertensive medication.[9] While there is little debate about the prolonged or lifelong use of medications in the management of other common chronic health conditions, the use of methadone in the management of chronic heroin addiction has stirred considerable professional and public controversy.[10]

A strong anti-medication bias pervades the history of addiction treatment and recovery in the United States. This antipathy toward medications is rooted in efforts to treat addiction with drugs that later were revealed to have great addictive potential. This history spans the treatment of morphine addiction with cocaine (1870s and 1880s) and the treatment of alcohol dependence with opium, morphine, cocaine, amphetamines, sedatives, and tranquilizers. The practice of defining recovery or abstinence as incompatible with the use of any mood-altering medications flows from this history.[11] It is within this context that we will explore the development and evolution of methadone maintenance as a medical treatment for opioid dependence in the United States.

THE HISTORY OF METHADONE MAINTENANCE

There are excellent histories of the development and evolution of methadone maintenance.[12] The purpose of this article is not to retell the story of methadone maintenance, but to draw from existing accounts to illustrate two ideally complimentary but often contrasting visions of MM: one focused on long-term personal recovery and the other on the reduction of personal and social harm. The prominence of one or the other of these visions has exerted a profound influence on the evolving nature of MM treatment, patients' perception and experience of MM, and public and professional attitudes toward MM. We will pay particular attention to changes in key MM clinical practices that have a clear connection to recovery initiation, recovery maintenance, and quality of personal and family life in long-term recovery.

---

8. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor, 9*(3), 24-33.

9. Dole, V.P. (1994). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, *118*, 304-309. Joseph, H., & Dole, V.P. (1970). Methadone patients in probation and parole. *Federal Probation*, *34*(2), 42-48.

10. Stimmel, B. (1999). Heroin addiction and methadone maintenance: When will we ever learn? *Journal of Addictive Diseases*, *18*(2), 1-4. White, W. (2009a). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

11. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

12. Brecher, E. (1972). *Licit and illicit drugs*. Boston: Little, Brown and Company. Dole, V.P. (1971). Methadone maintenance treatment for 25,000 addicts. *Journal of the American Medical Association*, *215*, 1131-1134. Dole, V.P. (1989). Interview. In D. Courtwright, & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press. Dole, V.P. (1994). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4. Dole, V.P., & Nyswander, M.E. (1965). A medical treatment for diacetylmorphine (heroin) addiction. *Journal of the American Medical Association*, *193*, 646-650. Dole, V.P., & Nyswander, M.E. (1966). Rehabilitation of heroin addicts after narcotic blockade with methadone. *New York State Journal of Medicine*, *66*, 2011-2017. Dole, V.P., & Nyswander, M.E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, *118*, 304-309. Kreek, M.J. (1993). Epilogue—a personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone guidelines: Treatment Improvement Protocol (TIP) Series 1*. Rockville, MD: Center for Substance Abuse Treatment. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305. Kreek, M.J. (2000). Methadone-related opioid agonist pharmacotherapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of New York Academy of Science*, *909*, 186-216. Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186. Payte, J. T. (1991). A brief history of methadone

OPIOID ADDICTION TREATMENT BEFORE METHADONE MAINTENANCE

Opioid addiction in the United States grew in tandem with a series of innovations: the isolation of the alkaloids morphine (1806) and codeine (1820) from opium, the introduction of the hypodermic syringe (1853), the sophisticated marketing of opiate-based patent medicines (late 1800s), and the introduction of heroin as an alternative to morphine (1898). Nineteenth century opium and morphine addicts seeking recovery were preyed upon via opiate-laced miracle cures promulgated by the same patent medicine industry that had long supplied them with opiate-based medicines. Medical treatments for opiate dependence in the U.S. during this early era focused on the best procedures and pacing of withdrawal and strengthening the patient's physical, emotional, and moral constitution. Such treatment was provided via prolonged institutional care in specialized inebriate asylums (e.g., the DeQuincey Home, the Brooklyn Home for Habitués), brief outpatient treatment in private addiction cure institutes (e.g., the Keeley, Neal, Gatlin, or Openheimer Institutes), or by private physicians, some of whom specialized in the treatment of opiate addiction. Treatment across all of these settings was usually followed by relapse. Intractable addicts—most with accompanying chronic medical problems—were maintained on opium or morphine by their physicians or, more commonly, were subjected to ineffective and potentially lethal withdrawal schemes.[13]

Following passage of the Harrison Tax Act[14] in 1914 and a 1919 Supreme Court decision (Webb v. United States) that interpreted such maintenance as criminal, 44 communities established morphine maintenance clinics (1919-1923). The clinics were criticized by the medical establishment and were subsequently closed under threat of criminal indictment. Private physicians were allowed to legally detox patients using diminishing doses of opiates, but those who attempted a maintenance treatment approach faced arrest and prosecution by the Bureau of Narcotics. Through the early twentieth century, cultural responsibility for the management of opioid addiction was transferred from the medical community to the criminal justice system.

When prisons became inundated with addicts who had violated the Harrison Act, Congress passed legislation (1929) that provided for the construction of two federal "narcotics hospitals" (prisons/"farms")—one in Lexington, Kentucky (1935) and one in Fort Worth, Texas (1938). Beyond the Lexington and Forth Worth facilities, few resources existed for the treatment of opioid addiction. The exceptions included a small number of state facilities (e.g., State Narcotics Hospital in Spadra, California, 1928-1941), private hospitals, and psychiatrists who catered to addicted persons of affluence.

---

in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison (Eds.), *Heroin in the age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage. Senay, E.D., Lewis, D.C., & Millar, D.G. (1997). The history and current status of drug substitution therapy for narcotic addiction in the United States. In *Medical prescription of narcotics* (pp. 189-200). Seattle: Hogrefe & Huber.

13. Kleber, H., & Riordan, C. (1982). The treatment of narcotic withdrawal: A historical review. *Journal of Clinical Psychiatry, 43*(6), 30-34. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

14. The Harrison Tax Act in effect made physicians the cultural gatekeepers of access to narcotic drugs by levying a tax on narcotic distribution and providing licenses for such distribution only to physicians. Musto, D. (1973). *The American disease: Origins of narcotic controls*. New Haven: Yale University Press.

Noteworthy in this early history is the limited availability and access to treatment, the risk of harmful treatment (prolonged sequestration, injury from medications and medical procedures, financial exploitation), and the absence of models of sustained, community-based support for addiction recovery—no sustained professional treatment or support protocols, no opioid addiction recovery mutual aid societies, and no visible role models of recovery from opioid addiction. The pathways to recovery from narcotic addiction, if they existed in this era, were hazardous and poorly marked.

THE CONTEXT FOR METHADONE MAINTENANCE

The development of methadone maintenance in the early 1960s occurred within a unique historical context. First and foremost was the dramatic rise in heroin addiction following World War II and the Korean War, particularly among adolescents and transition-age youths. This triggered a number of responses, including church-sponsored counseling clinics, hospital detoxification units, and the first specialized adolescent addiction treatment unit in the country—a 141-bed facility opened in 1952 at Riverside Hospital.[15] Also of note were efforts to adapt the program of Alcoholics Anonymous as a framework of sustained recovery for heroin addicts, e.g., Addicts Anonymous (1947), Habit Forming Drugs (1951), Hypes and Alcoholics (early 1950s), and Narcotics Anonymous (1950, 1953), but these groups were small, geographically limited, and often short lived. NA nearly died as an organization in 1959 and did not generate a viable service structure or sizeable membership until after MM was pioneered.

Psychiatric treatment of heroin addiction in the mid-twentieth century spanned electroconvulsive therapies, psychosurgery, aversion therapy, and psychotherapies from multiple theoretical schools, but none of these revealed any sustained promise of long-term recovery from heroin addiction. Criminal penalties for drug possession and sales were dramatically increased in 1951 and 1956, further filling the nation's prisons with heroin addicts. Follow-up studies of addicts treated at the two federal "narcotics farms" revealed relapse rates exceeding 90% following community re-entry. Riverside Hospital was closed in 1961 after a report documented exceptionally high post-treatment relapse rates. Synanon was founded in 1958 as the first ex-addict-directed therapeutic community (TC), but a thriving TC movement had not yet arisen in the U.S. when work on the development of MM began. States were experimenting with different approaches, including the use of civil commitments, to find some solution to the problem of opioid addiction.

15. White, W. (2004). Riverside Hospital: The birth of adolescent treatment. *Counselor*, *5*(2), 18-20.

Therapeutic pessimism regarding the treatment of opioid addiction spurred the American Medical Association, the American Bar Association, and other groups to call for renewed experiments in the treatment of heroin addiction, including experiments in opioid maintenance. Despite calls from such prominent groups, the Federal Bureau of Narcotics aggressively opposed all maintenance-based proposals for the treatment of heroin addiction on the grounds that such drug substitution was morally wrong and would lead to increased drug use.[16] But forces were coalescing to tip the social scales toward experimentation with maintenance.

THE BIRTH AND EARLY REFINEMENT OF METHADONE MAINTENANCE AS A MODEL TREATMENT

In 1964, Dr. Vincent Dole (an internist), Dr. Marie Nyswander (a psychiatrist), and Dr. Mary Jeanne Kreek (a medical resident) led a research project at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital to develop a medical treatment for heroin addiction. Collectively, they were involved in every aspect of the research, but they each made special contributions, with Dole taking the lead on the funding, policy, and politics of the project, Nyswander serving as the lead clinician, and Kreek leading the scientific studies and data collection. Controversy surrounded the project from its inception, including threats of criminal indictment. They avoided prosecution due to Dr. Dole's exceptional medical prominence prior to his work on heroin addiction and because of legal briefs prepared by the Rockefeller attorneys arguing that the Bureau of Narcotics' harassment of physicians offering medical maintenance of addicts was based on a misinterpretation of the Harrison Act—an argument the Bureau did not want tested in the courts. The fruits of the Rockefeller project set the stage for the diffusion of methadone maintenance treatment throughout the world.

The original pilot studies of MM in the mid-1960s occurred at a time when there was no national treatment system. A 1968 national survey revealed only 183 drug treatment programs in the United States, with more than 75% of these having been in existence for less than 5 years. By 1984, the number of drug treatment programs in the U.S. had grown to more than 3,000.[17] Methadone maintenance as a new medical treatment for addiction had to compete with alternative medications (e.g., narcotic antagonists-naltrexone) and treatment approaches using very different theoretical frameworks and clinical approaches (psychiatric treatment, therapeutic communities, faith-based counseling clinics). The birthing and earliest clinical replications of MM were marked by:

16. Musto, D. (1973). *The American disease: Origins of narcotic controls.* New Haven: Yale University Press. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems. White, W. L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148). Westport, CT: Auburn House.

17. Jaffe, J. (1987). Footnotes in the evolution of the American national response: Some little known aspects of the first American strategy for drug abuse and drug traffic prevention. The Inaugural Thomas Okey Memorial Lecture. *British Journal of Addiction*, *82*, 587-600.

- clinical studies concluding that short-acting opioids such as heroin and morphine were unsuitable as maintenance agents;[18]
- the discovery of methadone's unique effects on metabolic stabilization and its ability to induce cross-tolerance to other opioids ("blockade effect");[19]
- the publication of the original MM treatment protocol (a three-phase process of stabilization, counseling and rehabilitation, and maintenance) and clinical findings from the first pilots;[20]
- elaboration of a metabolic disease theory of addiction;[21]
- scientific studies of the actions and safety of methadone;[22]
- scientific confirmation that the physical, social, and occupational performance of stabilized patients was not impaired by methadone;[23]
- the extension of MM pilots to New York City hospitals/clinics/jails under the leadership of Drs. Freeman, Khuri, Lowinson, Millman, Newman, Primm, Trigg, Trussell, and New York City's Health Services Administrator Gordon Chase;[24]
- the transition from hospital-based induction into MM to ambulatory induction within outpatient clinics;[25]
- the integration of MM into multi-modality treatment systems in New York, Illinois, Connecticut, Massachusetts, Pennsylvania, and Washington, D.C. under the early leadership of Drs. Ramirez, Newman, Jaffe, Senay, Weiland, Kleber, and DuPont;[26]
- the early professionalization of MM as an addiction treatment specialty, e.g., the first National Methadone Conference (1968); and
- the increased scientific legitimacy of MM, including the first long-term outcome study of MM.[27]

Historically, MM marked the remedicalization of opioid addiction and the re-involvement of physicians and nurses in the medical treatment of opioid addiction. The innovation of MM was not the fact that it provided drug maintenance as a medical intervention for opioid dependence. As noted above, 44 clinics in the U.S. had provided morphine maintenance during the early twentieth century.[28] The core innovations were the unique properties that methadone brought to the maintenance process and the service milieus within which methadone was nested within the pilot sites. When Dr. Vincent Dole died in 2006, patients around the world were receiving methadone as a medical treatment for heroin addiction.[29]

---

18. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

19. Kreek, M. J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

20. Dole, V.P., & Nyswander, M.E. (1965). A medical treatment for diacetylmorphine (heroin) addiction, *Journal of the American Medical Association*, *193*, 646-650. Dole, V.P., & Nyswander, M.E. (1966). Rehabilitation of heroin addicts after narcotic blockade with methadone. *New York State Journal of Medicine*, *66*, 2011-2017. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309.

21. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, *118*, 304-309. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

22. Kreek. M.J. (1973). Medical safety and side effects of methadone in tolerant individuals. *Journal of the American Medical Association*, *223*, 665-668. Kreek, M.J. (1973). Plasma and urine levels of methadone: Comparison of four medication forms used in chronic maintenance treatment. *New York State Journal of Medicine*, *73*, 2773-2777.

23. Gordon, N.B. (1973). The functional status of the methadone maintained person. In L.R.S. Simmons & M.B. Gold (Eds.), *Discrimination and the addictions* (pp. 101-123). Beverly Hills, CA: Sage Publications.

24. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28. Newman, R.G. (2006). Expansion of opiate agonist treatment: An historical perspective. *Harm Reduction Journal, 3*(20), 1-5. M. Parrino, personal communications, February 11, 2010, and March 4, 2010.

25. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison (Eds.), *Heroin in the age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

26. These early multimodality treatment systems were financially supported primarily by grants from the Narcotics Division of the National Institute of Mental Health, headed by Dr. Sidney Cohen.

27. Gearing, F.R. (1974). Methadone maintenance treatment five years later—where are they now? *American Journal of Public Health. 64*, 44-50.

28. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

29. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28.

One early change in the design of MM is very important to the theme of this monograph. Before the MM pilot began, Dr. Dole conceptualized medication maintenance as a palliative care model that focused on reduction of personal and social harm—*"a medication that would keep addicts content without causing medical harm and that would be safe and effective for use over long periods in relatively stable doses… The goal of social rehabilitation of addicts was not part of the original plan."*[30] What shifted this theoretical perspective of palliative care almost immediately was the patients' unexpectedly positive response to methadone as a stabilizing medication and the active involvement of Drs. Dole, Nyswander, Kreek, and other staff in the rapidly changing lives of their patients. Within weeks of initiating MM, patients who on other opioid medications had been obsessed only with the schedule of drug administration began to pursue other activities and talk about their futures.[31] The goal of MM then shifted from palliation to an active and highly individualized process of recovery management. The elevated expectations accompanying this shift proved quite empowering to patients who in the past had been defined more by their problems than their possibilities. A large portion of the patients during this early era of MM in the United States were older heroin addicts whose lives had been consumed by heroin in spite of multiple treatment efforts and who now saw methadone as a new life-transforming treatment.

> *It was these [methadone maintenance] patients that gave all of us in those halcyon days such hope and enthusiasm as to the possibility of eventually cutting heroin addiction down to a small problem [in the United States].*[32]

EARLY THEORETICAL FOUNDATION FOR CLINICAL PRACTICES

An analysis of the early and subsequent writings of Dole, Nyswander, Kreek, and other early MM pioneers reveals ten theoretical premises that shaped the core clinical practices within the original model of MM.

1. **Heroin addiction is a genetically-influenced, chronic brain disease** (a metabolic disorder on par with diabetes) marked by the prolonged or permanent derangement of the patient's endogenous opioid receptor system. MM pioneers viewed heroin addiction not as a problem of deviance or "badness" but as a problem of "sickness"—a "brain disease with behavioral manifestations."[33] Recovery from heroin addiction thus required sustained medical supervision and medication management. MM rested on the proposition that primary cultural ownership of the problem of heroin addiction should rest with medical institutions rather than

30. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association*, *260*, 3025-3029.

31. Dr. Mary Jeanne Kreek, personal communication, April, 2010.

32. Kleber, H. (1977). Methadone maintenance treatment—a reply. *American Journal of Drug and Alcohol Abuse*, *4*(2), 267-272.

33. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309. Kreek, M.J. (2000). Methadone-related opioid agonist pharmacotherapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of New York Academy of Science, 909*, 186-216. For recent updates, see Trigo, J.M., Martin-Garcia, E., Berrendero, F. Robledo, P. & Maldonado, R. (2010). The endogenous opioid system: A common substrate in drug addiction. *Drug and Alcohol Dependence*, 108, 183-194, and Kreek, M.J. (2010). Overview and historical perspective of four papers presented on research related to the endogenous opioid system. *Drug and Alcohol Dependence*, 108, 195-199.

institutions that view addiction in terms of sin, vice (moral depravity), misbehavior, or crime.[34] MM as originally developed was a physician-directed, hospital-based model of medical care.[35]

2. **Methadone-facilitated metabolic stabilization is essential for most patients to achieve successful long-term recovery from heroin addiction; full biopsychosocial recovery is possible but is "corrective but not curative."**[36] Effective dose stabilization was posited as the foundation of biopsychosocial recovery within MM. It was assumed that efforts to treat heroin addiction that failed to account for the need for metabolic stabilization would fail for most patients.

3. **In the mid-1960s, methadone was discovered to have unique properties as a medical treatment for heroin addiction:** no increase in tolerance over time (although stress-induced neurobiological changes may require dose increases or decreases over time); no impairment from euphoria or sedation; success in relieving withdrawal distress and cravings; long duration of effect (24-36 hours); high relative safety; minimal side effects; and low cost.[37] Methadone was viewed as analogous to the use of insulin in the metabolic stabilization of diabetes. "With a relatively steady concentration [of methadone] in the blood, the narcotic receptors in critical cells remain continuously occupied and the patient becomes functionally normal."[38] In this view, the foundation of methadone-assisted recovery is the oral administration of an individualized effective dose of methadone on a daily basis.

4. **Effective metabolic stabilization and achievement of blockade effects (e.g., prevention of effects from injected heroin) is contingent upon the individual receiving his/her optimal daily dose of methadone.** This belief led to average daily doses of methadone within the MM pilot programs ranging from 80-120mgd.[39] Subsequent research confirmed the wide range of dosages required to produce the same therapeutic blood levels as a result of patient variability in methadone metabolism.[40]

5. **The dosage of methadone required for effective stabilization varies considerably from patient to patient and can vary modestly for the same patient over time.** This finding led to an early emphasis on individualized methadone dosing and adjustments in each patient's methadone dose over time as needed. There were no arbitrary floors or ceilings on methadone dosage; average methadone doses were also expected to change over time in response to changes in heroin purity and in response to new patterns of use (e.g., increased use of prescription opioid medications within the illicit drug culture).

---

34. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison Eds.), *Heroin in the age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

35. It is historically noteworthy that the metabolic theory of heroin addiction, later reformulated as receptor system dysfunction, anticipated the discovery of specific opioid receptors. Dr. Dole undertook the first study to look for opiate receptors, but this discovery would not be made until 1973 by three independent research teams, led respectively by Candace Pert and Solomon Snyder, Eric Simon, and Lars Terenius. Pert, C.B. & Snyder, S.H. (1973). Opiate receptor: demonstration in nervous tissue. *Science*, 179, 1011-1014. Simon, E.J., Hiller, J.M. & Edelman, I. (1973). Sterospecific binding of the potent narcotic analgesic (3H) Etorphine to rat-brain homogenate. *Proceedings of the National Academy of Science USA, 70, 1947-1949.* Terenius, L. (1973). Characteristics of the "receptor" for narcotic analgesics in synaptic plasma membrane fraction from rat brain. *Acta Pharmacologica et Toxicologica*, 33, 377-384. J. Woods, personal communication, March 15, 2010. See Ingolia, N.A., & Dole, V.P. (1970). Localization of d and l-methadone after intraventricular injection into rat brains. *Journal of Pharmacology and Experimental Therapeutics*, *175*, 84-87. Woods, J. (1994). The discovery of endorphins. Retrieved April 22, 2010 from http://www.methadone.org/library/woods_1994_endorphin.html.

36. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association, 260*, 3025-3029.

37. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association, 260,* 3025-3029. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine*, *118*, 304-309. Kreek. M.J. (1973). Medical safety and side effects of methadone in tolerant individuals. *Journal of the American Medical Association*, 223, 665-668. E. Senay, personal communication, February 16, 2010.

38. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association, 260,* 3025-3029.

39. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

40. Eap, C., Bourquin, M., Martin, J-L, Spagnoli, J., Livoti, S., Powell, K.,… Deglon, J. (2000). Plasma concentrations of the enantiometers of methadone and therapeutic response in methadone maintenance treatment. *Drug and Alcohol Dependence, 61*, 47-54.

6. **Chronic heroin addiction produces profound, persistent, recurring, and potentially permanent metabolic changes.** Prolonged cellular cravings for heroin and the high relapse rates associated with heroin addiction are consequences of metabolic impairment rather than a function of inadequate motivation, psychopathology, or environmental stressors; individually optimal doses of methadone provide daily correction of this impairment. Some MM patients maintain their recoveries following cessation of methadone without relapsing, but most patients are at high risk of opioid relapse and development of other drug dependencies following termination of MM—particularly patients with long opioid addiction careers.[41] Early studies found that relapse after discontinuation of MM was least likely for those with longer periods of time in MM, those who had achieved substantial rehabilitation, and those who had successfully completed treatment according to plan—a small minority of all MM patients.[42] Early MM was delivered with an understanding that most patients would need prolonged if not lifelong methadone maintenance.[43] There were no arbitrary limits on duration of methadone treatment and no professional pressure for patients to taper. Patients were maintained on methadone as long as they continued to derive benefits from it. They were further encouraged to carefully weigh the risks/benefits of tapering and were provided increased support during the tapering process. Returning patients were welcomed and re-admitted without guilt or shame. Addiction recovery was defined in terms of health and functionality and not viewed as contingent upon cessation of MM.
7. **"Addict traits" are a consequence, not a cause of addiction.**[44] In the view of MM pioneers, chronic heroin addiction is a problem of neuropathology, not psychopathology. Addiction was not viewed as a manifestation of mental illness, personality flaws, emotional pain related to trauma and loss, or inadequate coping skills. They argued that the biological roots of heroin addiction should not be confused with the psychological or social sources of heroin experimentation and use.[45] The success of MM-assisted treatment/recovery was not believed to be contingent upon a specific psychiatric treatment. Counseling to maximize emotional stabilization was directed primarily at lifestyle reconstruction, e.g., housing, family/social relationships, education, work, leisure.[46] In the words of Dr. Marie Nyswander, "… drug addicts, like other patients with medical illnesses, have attending or causative emotional problems, [but] they may neither need nor want psychiatric help."[47]

41. Des Jarlais, D.C., Joseph, H., Dole, V.P., & Schmeidler, J. (1983). Predicting post-treatment narcotic use among patients terminating from methadone maintenance. *Journal of Advances in Alcoholism and Substance Abuse, 2*(1), 57-68. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association*, *260*, 3025-3029. Kreek, M.J. (2000). Methadone-related opioid agonist pharmacotherapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of New York Academy of Science, 909*, 186-216.

42. Stimmel. B., & Rabin, J. (1974). The ability to remain abstinent upon leaving methadone maintenance: A prospective study. *American Journal of Drug and Alcohol Abuse*, *1*, 379-391.

43. Jaffe, J. (1972). The maintenance approach to the management of opioid dependence. In C. Zarafonetis (Ed.), *Drug abuse: Proceedings of the international conference* (pp. 161-170). Philadelphia: Lea and Febiger.

44. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24. Dole, V.P., Nyswander, M.E., & Kreek, M.J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309.

45. Nyswander, M. (1956). *The drug addict as a patient*. New York: Grune & Stratton.

46. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

47. Nyswander, M. (1956). *The drug addict as a patient*. New York: Grune & Stratton.

8. **Metabolic stabilization produced by MM does not, by itself, constitute recovery from heroin addiction; methadone-mediated metabolic stabilization of heroin addiction makes broader biopsychosocial rehabilitation possible.**[48] Early MM included a broad menu of services designed to promote global health and community reintegration, including provision of or linkage to resources for treatment of co-occurring medical/psychiatric problems and secondary drug dependencies.[49] The provision of ancillary services must be individualized by need, from no such services needed to multiple and prolonged services.

9. **MM-assisted recovery initiation and maintenance is enhanced within a supportive service milieu—a vibrant recovery culture and a sustained recovery support partnership between MM staff and their patients.** The service milieu and service relationship are potent ingredients, valuable components that help maximize the potential of methadone maintenance in achieving/sustaining recovery. There was an emphasis in early MM programs on compassion and professional respect and rapport. Early units remained small (maximum of 75 patients) to ensure a close connection between staff and each patient.[50] Peer supports were provided by stabilized patients who were hired as "research assistants" who could "speak from the authority of personal experience," inspire hope in new patients, and serve as guides in the service process.[51] There was intense support for education, employment, and pursuit of personal goals. Service relationships were marked by listening, encouragement, and continuity of contact over time, with patients actively involved in clinical decision-making—including determination of personally optimal doses.[52]

10. **The structure of daily clinic participation that enhanced early biopsychosocial stabilization within MM can constitute an obstacle to full recovery once patients begin to reconstruct a prosocial life in the community.** There was growing recognition that the requirement for daily clinic contact could inhibit later-stage recovery by sustaining contact with recent and active drug users and by interfering with opportunities for education, employment, career advancement, family life, and travel. There was also an understanding that sustained recovery management of stable patients by a personal physician could improve overall medical care of patients (comparable to management of other chronic diseases), provide greater assurance of confidentiality, reduce stigma-related problems, and enhance quality of life in long-term recovery. Interest in non-clinic options for MM grew in tandem with the number of patients who had achieved complete social rehabilitation. Medical maintenance provision of monthly visits

48. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

49. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines, Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment. McLellan, A. T., Arndt, I. O., Metzger, D. S., Woody, G. E., & O'Brien, C. P. (1993). The effect of psychosocial services in substance abuse treatment. *Journal of the American Medical Association, 269*, 1953-1957.

50. Hentoff, N. (1967). *A doctor among the addicts*. New York: Rand McNalley & Company.

51. Hentoff, N. (1967). *A doctor among the addicts*. New York: Rand McNalley & Company.

52. Ashton, M. (2005). Methadone maintenance: The original. *Drug and Alcohol Findings, 14*, 20-21. Joseph, H., & Woods, J. S. (2006). In the service of patients: The legacy of Dr. Dole. *Heroin Addiction and Related Clinical Problems*, *8*(4), 9-28.

for take-home methadone (in diskette or tablet form) from physicians' offices rather than the individual portions of juice provided in plastic bottles at MM clinics—was pioneered in the early 1980s as a viable alternative for highly stabilized patients, but its availability remains extremely limited.[53]

Theory was important to the development of particular clinical practices within MM, and several of these practices reflect what we will later define in this monograph as recovery-oriented clinical practices, e.g., transitioning from acute biopsychosocial stabilization to support for long-term biopsychosocial recovery, a relationship marked by personal encouragement and continuity of contact over an extended period of time, and availability of peer supports. There were two aspects to the biological emphasis in the metabolic theory of addiction and the central innovation of methadone that limited the recovery orientation in the evolution of MM. (We will explore these issues in greater depth in article three of this monograph.)

First, opioid dependence was viewed as a specialized disorder, and, as a result, MM treatment was aimed at and explicitly evaluated in terms of remission/reduction/cessation of heroin use as opposed to focusing on a larger construct of recovery from addiction. As a result, Opioid Treatment Programs (OTPs) historically have not provided for their patients a coherent rationale for abstinence from alcohol and other drugs, as has occurred in other addiction treatment modalities, nor have OTPs integrated the core technologies used in other treatment modalities to address patterns of and vulnerabilities to multiple drug use. At a systems level, this also created MM clinics that were isolated from the larger addiction treatment and recovery communities—isolation that left both MM staff and patients marginalized from these larger communities.

Second, the metabolic disease theory placed primary emphasis on the importance of pharmacological stabilization. Missing was a larger theoretical outline of how the addiction process poisoned personal character and interpersonal relationships and, as a result, how recovery involves not just a cessation of heroin use but a reconstruction of personal values, personal identity, and one's relationship to family, friends, and community. The biological rationale for MM also provided little in the way of a framework to consider spirituality (including life meaning and purpose) as a potentially important dimension of the recovery process. What that has meant throughout the history of MM is that mainstream MM patients have never been afforded the scope and intensity of educational and counseling experiences routinely provided to those in other addiction treatment modalities.

---

53. Novick, D.M., & Joseph, H. (1991). Medical maintenance: The treatment of chronic opiate dependence in general medical practice. *Journal of Substance Abuse Treatment, 8*, 233-239. Novick, D.M., Joseph, H., Salsitz, E.A., Kalin, M.F., Keefe, J.B., Miller, E.L., & Richmond, B.L. (1994). Outcomes of treatment of socially rehabilitated methadone patients in physicians' offices (medical maintenance): Follow-up at three and a half to nine and a fourth years. *Journal of General Internal Medicine, 9*, 127-130. Salsitz, E.A., Joseph, H., Frank, B., Perez, J., Richmond, B.L., Salomom, N., & Novick, D.M. (2000). Methadone medical maintenance treating chronic opioid dependence in private medical practice: A summary report (1983-1998). *The Mount Sinai Journal of Medicine*, *67*, 388-397. Senay, E.D., Barthwell, A.G., Marks, R., Bokos, P., Gillman, D., & White, R. (1993). Medical maintenance: A pilot. *Journal of Addictive Diseases*, *12*(4), 59-76.

The counseling bar has been set low in MM, dominated by mechanics of medication management and regulatory compliance within counselor caseloads that would be unthinkable in other modalities. Services aimed at assertive recovery management and lifestyle reconstruction have generally been viewed within MM programs as "ancillary" or optional "wrap-around" services to the pharmacotherapy that was viewed as the primary mechanism of MM treatment.

EARLY CHALLENGES

There is a tendency to portray the mid- to late 1960s and early 1970s as the Camelot period or "Golden era" for MM,[54] but the realities are much more complex. There were many problems that plagued the earliest years of MM—and some of them endure to the present. These included challenges in:

- determining optimum therapeutic dosages of methadone, optimum duration of methadone maintenance, effective tapering procedures, and post-tapering support protocols to reduce relapse risks;
- defining the optimal multidisciplinary team to operate a MM clinic;
- competing with private physicians who claimed to be providing addiction treatment but who only prescribed methadone;[55]
- minimizing the number of deaths from methadone, e.g., deaths from high-dose induction, overdoses among neophyte users from diverted methadone, and accidental ingestion by children—problems compounded early (1969-1970) by private physicians financially profiting from prescribing liberal quantities of methadone;[56]
- determining the most clinically effective procedures for central intake units to match individual patients to particular treatment options, e.g., pharmacotherapies such as methadone detoxification, methadone maintenance, and narcotic antagonists; therapeutic communities (TCs); and other residential programs and outpatient psychosocial programs;
- managing the intense conflict and competition among programs, particularly between MM and TC advocates;[57]
- developing clinical and administrative responses to continued opioid use and other drug and alcohol use after MM induction;

54. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

55. J. Jaffe, personal communication, March 10, 2010.

56. DuPont, R.L. (2002). Heroin addiction in the nation's capital, 1966-1973. In D. Musto (Ed.), *One hundred years of heroin* (pp. 67-90). Westport, CT: Auburn House. Jaffe notes: "Some [private physicians prescribing methadone doses as high as 300 mg] used a different algorithm in which the methadone dose was related to the size of the fee paid by the patient." J. Jaffe, personal communication, March 10, 2010.

57. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

- formulating protocols to respond to co-occurring medical and psychiatric disorders among MM patients;
- garnering sufficient financial resources to sustain methadone clinic operations—a process that required finding a balance between cost effectiveness and clinical effectiveness in defining the billable units of MM clinic services; and
- responding to professional and community criticism of MM, including great difficulties in finding locations for MM clinics acceptable to the community—a subject we will return to shortly.

Perhaps the most challenging demand was the need to refine a new addiction treatment modality while simultaneously responding to a demand for treatment that far outstripped available capacity. The early MM programs in cities like New York City, Washington, D.C., Chicago, New Haven, and Philadelphia could respond to only a small fraction of those needing treatment, and most cities had few if any resources to respond to a heroin epidemic that was peaking across the country.

EARLY RECOVERY ORIENTATION OF MM

In 1968-1970, the emerging multimodality treatment systems spoke of rehabilitation rather than recovery and defined rehabilitation in terms of three goals: reduced drug use, reduced criminal activity, and increased employment. Although there was not a "recovery consciousness" per se in the early MM clinics, there were several key clinical practices that the present authors will later define in this monograph as essential elements of a recovery-oriented model of methadone maintenance. These elements included:

- **Rapid Service Access:** Within the early MM clinics in New York City and Washington, D.C., every effort was made to expand treatment availability, speed service initiation, and stay connected to those on waiting lists for treatment as MM availability increased. The extent of early demand is evident by the two-year waiting list for admission into New York MM clinics in 1967.[58] In 1969, the Narcotics Treatment Administration (NTA) in Washington, D.C. admitted 2,000 heroin addicts into 12 treatment programs within its first two months of operation[59]: "At that time NTA would rather treat two people half as well than one person in the best way possible. We did not want to leave anybody on a waiting list… We always had room for another heroin addict to come in off the street."[60]

58. Hentoff, N. (1967). *A doctor among the addicts*. New York: Rand McNalley & Company.

59. DuPont, R.L. (2002). Heroin addiction in the nation's capital, 1966-1973. In D. Musto (Ed.), *One hundred years of heroin* (pp. 67-90). Westport, CT: Auburn House.

60. DuPont, R.L. (2005). Conversation with Robert L. DuPont. *Addiction, 100*, 1402-1411.

- **Patient Choice:** Patients most often entered treatment through a central intake unit that considered patient preference in linking patients to a particular treatment modality/organization. The assessment process was independent from the treatment process and provided options and respect for patient choices. It was clear from the beginning that some persons addicted to heroin were achieving recovery in treatment modalities other than MM, but it was (and remains) unclear which patients can recover with these other options, which will benefit from short-term maintenance, and which will require prolonged and potentially lifelong maintenance.[61]
- **Effective/Individualized Dose Stabilization:** Methadone doses were individually set based on patient need without arbitrary ceilings on doses that could be prescribed. Most early programs maintained the average 80-120 mg per day "blockade levels" originally pioneered by Dole, Nyswander, and Kreek.
- **Therapeutic Response to Continued Drug Use:** Drug testing was integrated into the MM clinical protocol as soon as it became available. It served multiple purposes, including the inhibition of methadone diversion and a means of providing timely therapeutic responses to continued drug use (e.g., dose adjustments, intensified counseling). Testing conveyed the message that the continued use of illicit drugs was incongruent with personal recovery and a potential threat to clinic participation.
- **Chronic Care Perspective:** Heroin addiction was viewed as a chronic, relapsing disorder whose treatment required prolonged if not lifelong medical and psychosocial support. There were no limits placed on length of MM treatment, nor was there pressure from staff for patients to taper. Sustainable recovery was viewed as requiring continued or intermittent treatment of most patients over a number of years.[62]
- **Therapeutic Alliance:** There was emphasis on forging a sustained, respectful relationship between MM clinic staff and each patient. This relationship was viewed as a critical dimension of the success of MM.[63]
- **Recovery Role Models:** People in stable medication-assisted recovery from heroin addiction were integrated into the treatment milieu in multiple roles, to affirm the potential for long-term recovery from heroin addiction and to serve as recovery guides for new patients.

---

61. J. Jaffe, personal communication, March 10, 2010.

62. Jaffe, J. (1969). *Possible solutions to the drug dependence and abuse problem.* Presented at the Michigan Governor's Conference on Drug Dependence and Abuse, December 18, 1969.

63. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

- **Focus on the Whole Person:** Methadone pharmacotherapy was wrapped in a larger menu of medical, psychiatric, and social support services (housing, employment, legal) aimed at enhancing global health and quality of life.
- **Safety Net:** MM clinics developed special programs for patient populations whose needs exceeded the services available in mainstream clinics (e.g., specialty programs for women, younger patients, patients with serious psychiatric illness, patients with co-occurring severe alcohol problems, chronically relapsing patients). Referral to other programs/modalities was used as a safety net based on the assumption that the lack of optimal response was sometimes a function of the program or bad chemistry in the program-patient relationship rather than a function of patient pathology.[64]
- **Community as Patient:** The organizations that first extended the MM model (e.g., those in New York City, Washington D.C, Chicago, New Haven) viewed themselves not as health care businesses but as public health agencies. In a very real sense, they viewed the community as their patient and sought mobilization of a community-wide response to problems of addiction.[65]

Other recovery-focused elements (e.g., recovery-focused patient and family education, collaboration with and assertive linkage to local recovery mutual aid groups, assertive follow-up of patients following successful tapering or disengagement) were weak or missing from early MM treatment models.

FUNDING, DIFFUSION, AND REGULATION OF METHADONE MAINTENANCE

The mid-twentieth-century heroin epidemic peaked (in terms of incidence of new heroin use) between 1969 and 1971.[66] On the domestic front, there was alarm about rising drug use (particularly heroin use) and its most visible manifestation: escalating crime rates. That alarm intensified in 1971 when two members of Congress returned from a visit to Vietnam and reported that "10-15% of GIs were addicted to heroin."[67] Fears of ever-escalating, drug-fueled crime and legions of addicted soldiers returning from Vietnam (which never materialized) triggered unprecedented action. On June 17, 1971, President Richard Nixon declared a "war on drugs" and announced the creation of the Special Action Office for Drug Abuse Prevention (SAODAP) to coordinate a national response to the growing drug problem. The resulting federal strategy balanced traditional drug supply-reduction efforts with expanded activities related to drug demand reduction (e.g., prevention and treatment).[68]

---

64. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

65. DuPont, R.L. (2005). Conversation with Robert L. DuPont. *Addiction, 100*, 1402-1411.

66. DuPont, R.L. (2002). Heroin addiction in the nation's capital, 1966-1973. In D. Musto (Ed.), *One hundred years of heroin* (pp. 67-90). Westport, CT: Auburn House.

67. Jaffe, J. (1987). Footnotes in the evolution of the American national response: Some little known aspects of the first American strategy for drug abuse and drug traffic prevention. The Inaugural Thomas Okey Memorial Lecture. *British Journal of Addiction*, *82*, 587-600. Jaffe. J. (2002). One bite of the apple: Establishing the Special Action Office for Drug Abuse Prevention. In D. Musto (Ed.), *One hundred years of heroin* (pp. 43-53). Westport, CT: Auburn House.

68. Jaffe, J. (1987). Footnotes in the evolution of the American national response: Some little known aspects of the first American strategy for drug abuse and drug traffic prevention. The Inaugural Thomas Okey Memorial Lecture. *British Journal of Addiction*, *82*, 587-600.

This unprecedented federal investment in addiction treatment was led by two individuals, Drs. Jerome Jaffe and Robert DuPont, each of whom had led multimodality treatment systems—Jaffe in Chicago and DuPont in Washington, D.C. Based on their collective experience, they convinced the White House that methadone maintenance was an essential element of any comprehensive strategy and that it could exert a direct, rapid effect on urban crime rates. The resulting infusion of federal dollars led to the rapid expansion of addiction treatment programs—MM clinics, therapeutic communities, outpatient counseling programs—across the country. The speed of MM diffusion was staggering—from 22 patients in 1965 and less than 400 patients in 1968 to more than 80,000 patients in 1976.[69] It should be noted that much of the expansion of MM was in New York City (36,000 by 1972), and that many American cities with significant opioid dependence problems did not provide MM, in part due to political controversies surrounding maintenance treatment. The New York City Health Department under the leadership of health czar Gordon Chase pushed the rapid expansion of MM in spite of cautions from even the most ardent MM defenders to avoid replicating MM too quickly. Chase acted on his belief that the prevalence of heroin addiction in New York City required a significant treatment response and that the most effective means of engaging those in need of treatment was through methadone maintenance.[70]

This rapid expansion of MM programs led to federal and state regulatory structures, program licensure requirements, and new funding guidelines that exerted a profound and oft-debated influence on MM clinical practices. These new regulatory guidelines contributed to the dramatically enhanced availability, quality, credibility, and acceptability of MM. They restricted who could provide MM to approved clinics and hospital pharmacies—an effort that deterred private physicians from profiteering from methadone prescriptions. They also restricted who could have access to MM—a response to allegations that physicians were prescribing methadone to non-dependent heroin users.[71] Without such requirements and guidelines, funding for MM would have been unlikely, and unacceptable practices in the worst-managed MM clinics could have triggered a backlash that would have threatened the very existence of MM. In a comparison of MM diffusion with such requirements to MM diffusion in countries that lacked such structures, it becomes clear that these requirements did serve to limit methadone diversion and methadone-related deaths.[72]

The 1980s were marked by two successive presidential administrations (Carter and Reagan) in which White House Policy advisors were first lukewarm to MM and then distinctly anti-methadone. Diminished public funding support for MM—by more than 50%[73]—changes in the core philosophy

69. White, W. L. (2002). Trick or treat? A century of American responses to heroin addiction. In D. Musto (Ed.), *One hundred years of heroin* (pp. 131-148). Westport, CT: Auburn House.

70. Dr. Robert Newman, Personal Communication, July 2, 2010.

71. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

72. J. Jaffe, personal communication, March 10, 2010.

73. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

of MM, and erosion of quality within many MM programs troubled early MM pioneers, as did the increasingly hostile attitudes toward MM at local and national levels.[74] Indicative of such erosion was the 1988 White House Conference for a Drug Free America, which called for the abolishment of MM and an investigation of NIDA for its support of MM. Dr. Herbert Kleber[75] describes 1988 as the "lowest point methadone reached, in terms of national policy." These years were marked by decreased public funding of MM, increased reliance on patient fees to support MM, and the dramatic growth of privately owned for-profit MM clinics.[76] But even at this low benchmark, some 200,000 patients were enrolled in MM in the United States.[77]

The most significant factor that brought MM back into policy favor was the spread of HIV/AIDS by injection drug users and growing evidence that MM significantly lowered the risk of HIV infection.[78] Public and professional alarm about rising rates of HIV infection and AIDS-related deaths pushed the primary rationale for methadone from a medical treatment for heroin addiction to a public health strategy of HIV/AIDS prevention. A more calculated harm-reduction approach to MM led to proposals for stripped-down versions of "interim MM" and "low-threshold MM." MM pioneer Vincent Dole was quite clear that such approaches to MM lacked the core technology and personal focus—what we refer to in this monograph as recovery orientation—of the original MM model.

> *… "harm reduction" is an improvement in the sterile policy of simply blaming the addict for having a chronic, relapsing disease. At present methadone is being dispensed liberally in various harm reduction programs throughout the world, with doses and schedules being guided by the wishes of the addicts. This is not entirely bad, but it is a poor way to practice medicine and is not the "methadone maintenance treatment" described in the early literature.*[79]

CHANGING CLINICAL PRACTICES IN MM IN THE 1970S AND 1980S

As MM programs spread in the 1970s and 1980s, several factors contributed to changes in core MM practices, their degree of effectiveness, and the cultural and professional perception of MM programs. First was the sheer level of demand for MM treatment. As waiting lists to enter MM lengthened, many programs responded by shortening treatment. They accomplished this by encouraging stabilized patients to taper/terminate MM and by administratively discharging patients for continued drug or alcohol use or for infraction of clinic rules.[80] Characteristics of patients entering MM evolved toward a younger, less motivated population that was more prone to view

74. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M. W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

75. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

76. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

77. J. Jaffe, personal communication, March 10, 2010.

78. Longshore, D., Hsieh, S., Danila, B., & Anglin, M.D. (1993). Methadone maintenance and needle/syringe sharing. *International Journal of the Addictions*, *28*, 983-996. Novick, D.M., Khan, I., & Kreek, M.J. (1986). Acquired immunodeficiency syndrome and infection with hepatitis viruses in individuals abusing drugs by injection. *Bulletin of Narcotics*, *38*(1-2), 15-25. Novick, D.M., Kreek, M.J., Des Jarlais, D.C., Spira, T.J., Khuri, E.T., Ragunath, J., Kalyanaraman, V.S., Miescher, A. (1986). Abstract of clinical research findings: Therapeutic and historical aspects. *Problems of Drug Dependence, 1984: Proceedings of the 47th Annual Scientific Meeting, The Committee on Problems of Drug Dependence, Inc* (pp. 318-320). Rockville, MD: National Institute on Drug Abuse.

79. Dole, V.P. (1997). What is "methadone maintenance treatment"? *Journal of Maintenance in the Addictions*, *1*(1), 7-8.

80. Perkins, M.D., & Bloch, H.I. (1971). A study of some failures in methadone treatment, *American Journal of Psychiatry*, *128*(1), 447-450.

methadone as just another drug, or a control device, rather than a medication that could aid addiction recovery. The quality of staff also changed with mass expansion. Second-generation staff were sometimes less capable and less enthusiastic about MM and more likely to view their work as "just a job." MM programs became increasingly characterized by inadequate staffing levels, hiring of staff philosophically opposed to maintenance, and relegating physicians (often in part-time positions) to conducting physicals and writing prescriptions rather than providing clinical leadership. Some of the newer expansion programs were also plagued with poor leadership and weak infrastructure (e.g., inadequate capitalization, facilities, and information technology) and were often perceived to be motivated more by financial gain than by community service.

Many of the new methadone programs and regulatory bodies governing MM grew without a foundational knowledge of the pharmacology and theoretical framework that had guided MM's early development. Dr. Dole later reflected on this period of mass MM diffusion.

> *With the growth of the programs, there was an adoption of methadone by people who still fundamentally believed that [heroin addiction] was a psychological problem. They were only using methadone as a means to engage somebody in treatment, with the ideas that ultimately the cure would be through psychotherapy… This type of attitude was adopted and expanded into an official view by the federal government, and it was incorporated in their regulations by 1974. The goal of [methadone maintenance] treatment was [from that period on] not rehabilitation but abstinence.*[81]

Dole was particularly incensed at the shift away from the use of methadone doses high enough to achieve a blockade effect and at arbitrary limits on length of MM treatment—trends he viewed as being based on political considerations rather than medical science or clinical judgment.[82] Dole[83] viewed each episode of tapering as "an experiment with the life of a patient" with potentially ominous outcomes that should not be undertaken without a sustained period of stability, the patient's request, and prolonged follow-up by the physician. In later interviews, Dole continued to criticize the mass diffusion of what he considered to be a watered down approach to MM:

> *There is no sense in multiplying [methadone maintenance] programs that are administered by people who do not understand the pharmacology of methadone, or who lack compassion and a grasp of what it is to be an addict.*[84]

Drs. Dole and Nyswander were critical of the loss of key ingredients of MM throughout the late 1970s

---

81. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

82. Cushman P., & Dole, V.P. (1973). Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association*, *226*, 747-752. Dole, V.P. (1973). Detoxification of methadone patients and public policy. *Journal of the American Medical Association, 226*, 780-781.

83. Dole, V.P. (1973). Detoxification of methadone patients and public policy. *Journal of the American Medical Association, 226*, 780-781.

84. Dole, V.P. (2002). Conversation with Vincent Dole. In G. Edwards (Ed.), *Addiction: Evolution of a specialist field* (pp. 3-10). Oxford: Blackwell Science Ltd. (Reprinted from Conversation with Vincent Dole, by Dole, V.P., 1994, *Addiction, 89*, 23-29).

and 1980s. They argued that "Bureaucratic control of methadone programs has given us 'slots,' a rule book, and an army of inspectors, but relatively little rehabilitation."[85] Dole's and Nyswander's criticism of the effects of federal regulation obscure the fact that some of the most restrictive of such regulations came not from the federal level but from states, counties, and cities. These criticisms also failed to acknowledge the fact that many methadone treatment providers resisted loosening MM regulations on the grounds that current regulations were essential for continued state funding of MM services.[86]

Dr. Dole later spoke of the "stagnation of treatment" that occurred throughout the 1970s and 1980s.[87] He was particularly incensed at the depersonalization of MM and the loss of partnership with patients in MM: "the contempt with which many regulators and program administrators have treated their patients seems to me scandalous."[88]

> *The strength of the early programs as designed by Marie Nyswander was in their sensitivity to individual human problems. The stupidity of thinking that just giving methadone will solve a complicated problem seems to me beyond comprehension.*[89]

Dole was not the only early MM pioneer who criticized the evolution of MM in the 1970s. In 1976, Dr. Robert Newman, who led the expansion of MM in New York City, declared:

> *Methadone maintenance treatment, with its unique, proven record of both effectiveness and safety, no longer exists. One can only hope that it is not too late to reassess that which has been cast aside, and to resurrect a form of treatment which has helped so many, and which could help many more.*[90]

Other critics, including Dr. Stephen Kandall, concurred with Newman and further argued that:

> *Political forces reduced methadone to an inexpensive, stripped down way to "control" a generation of addicts without having to provide essential rehabilitative services…* [91]

Whether one believes the mass diffusion and regulation of MM was a curse or a positive and essential stage in the maturation of modern addiction treatment, it is clear that key changes occurred in the philosophy and practice of MM in the 1970s and 1980s. Changes that have had the greatest impact on long-term medication-assisted recovery include the following, as reported in the literature and observed by the authors:

---

85. Dole, V.P., & Nyswander, M.E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

86. J. Jaffe, personal communication, March 10, 2010. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

87. Dole, V.P. (1996). Interview with Dr. Vincent Dole, M.D.: Methadone: The next 30 years? *Addiction Treatment Forum*, Winter, 1-6.

88. Dole, V.P. (1996). Interview with Dr. Vincent Dole, M.D.: Methadone: The next 30 years? *Addiction Treatment Forum*, Winter, 1-6.

89. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais, *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

90. Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186.

91. Kandall, S. (1996). *Substance and shadow: Women and addiction in the United States.* Cambridge, MA: Harvard University Press.

- **Purpose:** MM's primary focus shifted from personal rehabilitation to reduction in social harm (e.g., crime, violence, disease transmission); at policy levels, and sometimes at clinical levels, the whole person and the personal recovery process became an afterthought.[92] Protection of public safety/health and personal recovery are not incompatible, but emphasis on the former to the exclusion of the latter led to depersonalized and degrading treatment in some OTPs.[93] Increased privatization of MM (via for-profit methadone clinics) in response to cuts in public funding focused institutional missions on financial margins and led to cuts in ancillary services, as well as subsequent exposés of excessive profits in some clinics[94]—a situation that not only continues but has worsened.[95]
- **Variation in Quality:** There was widening variation in program adherence to accepted guidelines and best practices, and decreases in optimal care, as indicated by increased reports of adverse events and quality concerns raised by funding, licensing, and accreditation authorities.
- **Decreased Access:** Cuts to publicly funded methadone programs, program closings, and reduced MM treatment capacity increased MM waiting lists, prompted prolonged delays in treatment entry, created pressure for premature and involuntary tapering, and led to service fees that forced some patients into criminal activity to pay for MM[96]—all at a time when demand for MM treatment was increasing.[97]
- **Inadequate Dose Stabilization:** Arbitrary limits were imposed on methadone doses, with average MM dosages dropping from their original optimal range of 80-120mgd to 88% of MM patients receiving suboptimal doses (below 60mgd) in 1988.[98] Patient success became measured in terms of achievement of lower methadone doses and in getting patients off of methadone.[99]
- **Concerns about Patient Safety:** Some private clinics used exceptionally high doses (above 120mgd) to attract patients, in spite of the lack of research on long-term effects and effectiveness of such dosage levels.[100]
- **Shortened Treatment Duration:** Arbitrary limits were set for duration of MM, e.g., requirements for medical justification for sustaining treatment beyond two years, staff pressure for patients to progressively reduce methadone dosage and cease maintenance, extrusion of "troublesome" patients (i.e., those with the most severe and complex problems) via administrative discharge. One-year retention rates in MM in New York City dropped from an initial

92. Newman, R.G. (1987). Methadone treatment: Defining and evaluating success. *New England Journal of Medicine*, *317*, 447-450.

93. Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry*, *24*, 165-195.

94. Britton, B.M. (1994). The privatisation of methadone maintenance: Changes in risk behavior associated with cost related detoxification. *Addiction Research, 2*(2), 171-181.

95. Jackson, T. (2006). A methadone cash cow. *Treatment Magazine: Addiction Industry News*, November, 23-25. Herbert Kleber, personal communication, March 2010.

96. Knight, K.R., Rosenbaum, M., Irwin, J. Kelley, M.S., Wenger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362.

97. Ball, J. C. (1994). Methadone maintenance: A reply to the commentaries. *Addiction, 89,* 813.

98. D'Aunno, T., Foltz-Murphy, N., & Lin, X. (1999). Changes in methadone treatment practices: Results from a panel study: 1988-1995. *American Journal of Drug and Alcohol Abuse, 25*, 681-699. D'Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, *288*(7), 850-856.

99. Rosenbaum, M., & Murphy, S. (1984). Always a junkie?: The arduous task of getting off methadone maintenance. *Journal of Drug Issues*, *14,* 527-552. Woody, G.E., Luborsky, L, McLellan, A.T., O'Brien, C.P., Beck, A.T., Blaine, J., Hole, A. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry, 40*(6), 639-645.

100. E. Senay, personal communication, February 16, 2010.

98% to 59% ten years later.[101] With growing professional, family, and community expectations that MM should be as short as possible, opioid addiction became the only chronic disease in which patients were shamed and stigmatized for long-term medication adherence. With these changes, MM patients were denied pride in the achievement of sustained recovery stabilization—in marked contrast to those celebrating the length of their recoveries in AA, NA, and treatment alumni association meetings.

- **Lowered Expectations:** The shift from a rehabilitation to a harm-reduction philosophy led to tolerance of continued drug and alcohol use in some clinics.
- **Contraction of Service Menu:** There was a reduction in the range and intensity of medical, psychiatric, psychological, counseling, and social rehabilitation services provided, as funds to operate MM tightened and private programs discovered that providing fewer services generated greater profits.[102]
- **Regulator and Funder as the Patient:** Increased preoccupation with regulatory compliance and its ever-escalating paperwork burden: "[MM] Programs quickly learned that survival depended on the condition of the records and not the patients."[103] Close observers of MM throughout the 1970s and 1980s noted a shift in the character of the MM milieu from one of care, compassion, and choice to one of power, surveillance, and control.

The very understanding of recovery within the context of MM changed during the 1970s and 1980s. Whereas recovery was initially defined in the MM context in terms of global health and functioning irrespective of one's medication status, recovery later became defined as beginning only at the point of cessation of MM. This newly imposed goal of "abstinence" from the use of methadone created a definition of recovery that precluded the use of methadone as a medication. (The subject of the relationship between methadone and recovery status and the controversies surrounding this question will be the topic of the second article in this monograph). Ironically, a study by Des Jarlais, Joseph, Dole, and Schmeidler[104] found that the likelihood of sustaining abstinence from heroin after tapering from MM was greater in patients entering treatment in 1966-1967, when methadone doses were higher and sustained for longer time periods than in 1972, when methadone doses and maintenance duration were decreasing.

Many MM clinics valiantly struggled to maintain the core clinical practices and personal recovery focus of the early MM model, but others became little more than methadone dosing stations

---

101. D'Aunno, T., Foltz-Murphy, N., & Lin, X. (1999). Changes in methadone treatment practices: Results from a panel study: 1988-1995. *American Journal of Drug and Alcohol Abuse, 25*, 681-699. D'Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, *288*(7), 850-856. Dole, V.P., & Nyswander, M.E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

102. Kleber, H. (2002). Methadone: The drug, the treatment, the controversy. In D. Musto (Ed.), *One hundred years of heroin* (pp. 149-158). Westport, CT: Auburn House.

103. Zweben, J.E., & Payte, J.T. (1990). Methadone maintenance in the treatment of opioid dependence: A current perspective. *The Western Journal of Medicine, 152*(5), 588-599.

104. Des Jarlais, D.C., Joseph, H., Dole, V.P., & Schmeidler, J. (1983). Predicting post-treatment narcotic use among patients terminating from methadone maintenance. *Journal of Advances in Alcoholism and Substance Abuse, 2*(1), 57-68.

stripped of the rehabilitation services and recovery cultures that had once been essential parts of their character. As drug cultures flourished within and around these dosing stations (e.g., medication diversion, drug sales, prostitution), neighborhood acceptance of MM clinics, which was marginal at best, declined and was replaced by heightened opposition to MM. The worst-managed methadone clinics became the media-shaped face of methadone, and the best-managed clinics became virtually invisible. Myths and misconceptions about methadone flourished in this environment even among MM patients. Patient surveys found that while many believed methadone had positively affected their lives, they also believed that methadone could hurt their health and that its use should be terminated as soon as possible.[105]

Studies of patients clinically or administratively pushed out of MM revealed high rates of post-treatment heroin use, deaths, hospitalizations, arrests, incarcerations, and re-admission to MM. These findings led to calls for sustained retention of patients in MM.[106] Ethnographic studies of local drug cultures revealed that the early vision of MM-facilitated social rehabilitation became replaced by a lifestyle for many MM patients marked by visits to the MM clinic, supplemental alcohol and drug use (e.g., cocaine and fortified wine), panhandling and other criminal activity, and welfare dependence.[107] The erosion in quality of methadone maintenance, and its lost status as an effective, safe, and life-altering treatment for persistent heroin addiction, helped fuel the growing stigma and discrimination attached to MM. In spite of these limitations, a significant core of MM patients negotiated an increasingly oppressive system and forged their individualized recovery paths. Many of these otherwise invisible MM patients also became involved in advocacy, so that others could benefit from their experience, knowledge, wisdom, and tenacity. These patients and patient advocates are among the hidden heroes within the modern history of MM treatment.[108]

EARLY METHADONE CRITICS

One aspect of the story of MM we have not yet discussed is the heightened stigmatization of methadone as a medication, methadone maintenance treatment (particularly high-dose treatment), MM patients, and MM providers at cultural, governmental, and professional levels as well as within American communities of recovery.[109]

Media reports following the initial announcement of MM's development characterized methadone as a panacea—a "Cinderella drug" that induced miraculous changes in addicts. Methadone was portrayed in the popular press as the magic bullet that would solve the country's heroin addiction

105. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner-city methadone clinic. *Journal of Urban Health, 79*, 571-578.

106. Perkins, M.D., & Bloch, H.I. (1971). A study of some failures in methadone treatment. *American Journal of Psychiatry*, *128*(1), 447-450.

107. Preble, E., & Miller, T. (1977). Methadone, wine and welfare. In R.S. Weppner (Ed.), *Street ethnography.* Beverly Hills: Sage Publications.

108. Joyce Woods, personal communication, March 2010.

109. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi, & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine.* Thousand Oaks, CA: Sage. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association, 300*(9), 2303-2305. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Newman, R.G. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186. Newman, R.G. (1993). Methadone maintenance and recovery. *American Journal of Drug and Alcohol Abuse, 19*(1), 135-137. Newman, R. G., & Peyser, N. (1991). Methadone treatment: Experiment and experience. *Journal of Psychoactive Drugs, 23*(2), 115-121. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149. Vigilant, L. G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

problem.[110] Efforts by Dr. Jerome Jaffe and others to explain that the positive outcomes of MM programs were the result of a total rehabilitative effort and not just the use of methadone went unheeded. The public and professional focus remained on the perceived power of methadone as a medical "cure" for heroin addiction.

Early critics of MM (1970s and 1980s), including competing approaches to addiction recovery (e.g., therapeutic communities, Narcotics Anonymous) and government personnel whose views about maintenance had long been influenced by Bureau of Narcotics Chief Harry Anslinger, proffered 10 key criticisms of MM.

1. MM reinforces the illusion that there are *chemical answers to complex human and social problems.* This criticism came particularly from those who viewed the cause of heroin addiction to be rooted in poverty and racism and who feared this new medication would be a "technological fix" that diverted direct action on those underlying issues.
2. Methadone merely *substitutes a legal addiction for an illegal addiction*; it is a form of "legalized euphoria" that does not eliminate craving for heroin.
3. Addicts maintained on methadone suffer from *cognitive, emotional, and behavioral impairment:* MM is a "crutch"—a pharmacological shield that prevents addicts from adjusting to reality.[111]
4. Government distribution of methadone reflects an attitude of permissiveness that *contributes to youthful drug experimentation.*
5. The *positive effects attributed to MM in published research studies are over-stated.*
6. The *source of addiction* is rooted in the addict's character/personality, not his or her cells.
7. Treating heroin addiction with another opioid like methadone is *morally unacceptable*.
8. Methadone maintenance is a *tool of genocide and racial oppression.*
9. The methadone treatment industry *financially exploits* those it has pledged to serve.[112]
10. MM is a "hostile exercise in disciplining the unruly misuses of pleasure and in *controlling economically unproductive bodies*" through enforced dependency.[113]

Widely publicized criticisms of MM became part of the growing body of myths and misunderstandings that have plagued MM since its inception.[114] Such misconceptions exerted considerable

110. Senay, E.C. (1971). Methadone: Some myths and hypotheses. *Journal of Psychedelic Drugs*, *4*(2), 182-185.

111. Jackman, J. (1973). A hypothesis concerning the difficulty of withdrawal from maintenance on methadone. In *Proceedings of the Fifth National Conference on Methadone Treatment* (pp. 471-475). New York: HAPAN.

112. See Berry, 2007 for the most current presentation of this argument and Boudaris' 1975 contention that MM patients are tethered to daily clinic visits not out of clinical necessity but financial advantage to the clinics. Berry, L.C. (2007). *In$ide the methadone clinic industry: The financial exploitation of America's opiate addicts*. Tucson, AZ: Wheatmark. Boudouris, J. (1975). The economics of methadone programs. *British Journal of Addiction*, *70*, 374-380.

113. Ausbel, D.P. (1983). Methadone maintenance treatment: The other side of the coin. *The International Journal of the Addictions*, *18*(6), 851-862. Bourgois, P. (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. *Culture, Medicine and Psychiatry, 24*, 165-195. Brecher, E. (1972). *Licit and illicit drugs*. Boston: Little, Brown and Company. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11. Lennard, H.L., Epstein, L.J., & Rosenthal, M.S. (1972). The methadone illusion. *Science*, *176*(4037), 881-884. E. Senay, personal communication, February 16, 2010. White, W. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/ recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

114. Zweben, J.E., & Sorensen. J.L. (1988). Misunderstandings about methadone. *Journal of Psychoactive Drugs*, *20*(3), 275-280.

influence on how MM clinics and MM patients viewed themselves and how allied professionals, the public, and policymakers viewed MM treatment. At a most practical level, starting or relocating new MM clinics became increasingly difficult from the mid-1970s forward in a cultural climate filled with such views.[115] Most poignantly, MM patients faced stigma and discrimination from many quarters based on these perceptions, including within the larger addiction treatment field and local recovery mutual aid societies.[116]

TOWARD THE REVITALIZATION AND ELEVATION OF METHADONE MAINTENANCE

In 2003, Mark Parrino, President of the American Association for the Treatment of Opioid Dependence (AATOD), suggested that methadone maintenance was entering a renaissance period of renewal, revitalization, and potential transformation. This renaissance began in the late 1980s and early 1990s with the reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies, including the:

- Lasker Foundation (1988),[117]
- Institute of Medicine (1990),[118]
- American Society of Addiction Medicine (1990),[119]
- Government Accounting Office Report (1990),[120]
- Office of Technology Assessment of the United States Congress (1990),[121]
- Ball and Ross systematic review of MM outcomes (1991),[122]
- American Medical Association Council on Scientific Affairs (1994),[123]
- New York State Office of Alcoholism and Substance Abuse Services (1994),[124]
- California Drug and Alcohol Treatment Assessment (1994),[125]
- National Institutes of Health Consensus Conference on Effective Treatment of Heroin Addiction (1997),[126]
- American Public Health Association (1997),
- American Medical Association House of Delegates (1997),

115. Courtwright, D. (1997). The prepared mind: Marie Nyswander, methadone maintenance, and the metabolic theory of addiction. *Addiction*, *92*(3), 257-265.

116. White, W. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery)*. Philadelphia: Department of Behavioral Health and Mental Retardation Services.

117. Accessed April 20, 2010 at http://www.laskerfoundation.org/awards/1988_c_description.htm.

118. Institute of Medicine (1990). *Treating drug problems, Vol. 1*. Washington, DC: National Academy Press. Institute of Medicine (1995). *Federal regulation of methadone treatment*. (Richard A. Rettig and Adam Yarmolinsky, Editors). Washington, D.C.: National Academy Press. Institute of Medicine (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, D.C.: The National Academies Press.

119. American Society of Addiction Medicine. (1990, Revised 2006). *Methadone treatment of addiction: Public policy statement*. Retrieved November 2, 2009 from http:/www.asam.org/MethadoneTreatmentofAddiction.html.

120. U.S. General Accounting Office (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104).

121. Office of Technology Assessment, US Congress. (1990). *The effectiveness of drug abuse treatment: Implications for controlling AIDS/HIV infection*. Washington, DC: Office of Technology Assessment.

122. Ball, J.C., & Ross, A. (1991). *The effectiveness of methadone maintenance*. New York: Springer-Verlag.

123. Yoast R., Williams, M.A., Deitchman, S.C., & Champion, H.C.. (2001). Report of the Council on Scientific Affairs: Methadone maintenance and needle-exchange programs to reduce the medical and public health consequences of drug abuse. *Journal of Addictive Diseases, 20*, 15-40.

124. Joseph, H., & Woods, J.S. (Chemical Dependency Research Working Group). (1994). *Methadone treatment works: A compendium for methadone maintenance treatment*. New York State Office of Alcoholism and Substance Abuse Services.

125. Gerstein D., Johnson R. A., Harwood H., Fountain D., Suter N., & Malloy K. (1994). *Evaluating recovery services: the California Drug and Alcohol Treatment Assessment (CALDATA)*. California Department of Alcohol and Drug Programme Resource Center, Sacramento, CA.

126. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

- Office of National Drug Control Policy (1990, 1999),[127]
- National Institute on Drug Abuse (1999),[128]
- World Health Organization (2001), and
- Cochrane Review (2003).[129]

These well respected reviews confirmed that methadone delivered at sustained optimal daily dosages and combined with ancillary psychosocial services delivered by competent practitioners:

- decreases the death rate of opioid-dependent individuals by as much as 50%;
- reduces the transmission of HIV, Hepatitis B and C, and other infections;
- eliminates or reduces illicit opioid use;
- reduces criminal activity;
- enhances productive behavior via employment and academic/vocational functioning;
- improves global health and social functioning; and
- is cost-effective.[130]

The effectiveness of MM was affirmed, and MM became the primary method used worldwide in the medical treatment of heroin addiction "despite regulatory constraints and suboptimal performance by many programs."[131]

> *Today, the safety, effectiveness, and value of properly applied MMT is no more controversial [from the standpoint of science] than is the assertion that the earth is round.*[132]

As the international body of scientific studies supporting MM grew, Dr. Dole continued to communicate what MM could and could not do as a treatment for heroin addiction.

> *The treatment therefore, is corrective but not curative for severely addicted persons. A major challenge for future research is to identify the specific defect in receptor function and to repair it. Meanwhile, methadone maintenance provides a safe and effective way to normalize the function of otherwise intractable narcotic addicts.*[133]

---

127. Office of National Drug Control Policy. (March, 1999). *Policy paper—opioid agonist treatment.* Washington, DC: Executive Office of the President, Office of National Drug Control Policy.

128. National Institute on Drug Abuse. (1983). *Research on the treatment of narcotic addiction-State of the art.* US Department of Health and Human Services, Rockville, Maryland. National Institute on Drug Abuse (1999). *Principles of addiction medicine: A research-based guide* (NIH Publication No. 99-1180). Rockville, MD: National Institute on Drug Abuse.

129. Mattick R.P., Breen, C., Kimber, J., & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews, (Issue* 2):CD002209.

130. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

131. Dole, V.P. (1992). Hazards of process regulation: The example of methadone maintenance. *Journal of the American Medical Association*, *267*, 2234-2235.

132. Bell, J., & Zador, D. (2000) A risk-benefit analysis of methadone maintenance treatment. *Drug Safety, 22*(3), 179-190. Payte, J. T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

133. Dole, V.P. (1988). Implications of methadone maintenance for theories of addiction. The Albert Lasker Medical Awards. *Journal of the American Medical Association*, *260*, 3025-3029.

RECENT GROWTH OF METHADONE MAINTENANCE

The number of patients admitted to OTPs in the United States grew dramatically between 1998 and 2008—influenced by the growth in for-profit OTPs and new patterns of opioid addiction, e.g., increased addiction to pharmaceutical opioids. There are now 1,203 opioid treatment programs in 46 states (and the District of Columbia, U.S. Virgin Islands, American Samoa, and Puerto Rico), treating more than 260,000 patients on any given day.[134] A 2009 analysis provides the latest profile of OTPs in the United States:

- OTPs constitute only 8% of all U.S. addiction treatment facilities, but OTP patients constitute 23% of all patients in addiction treatment.
- 67% of OTPs serve only patients in medication-assisted treatment—reflecting the isolation of OTPs and their patients from the mainstream treatment system.
- 50% of OTPs are operated by for-profit organizations.
- Of 265,716 patients in OTP treatment in 2008, 99% were treated with methadone, and 1% were treated with buprenorphine.
- Half of all OTP patients pay out-of-pocket for their own treatment, at an average annual cost of $4,176 per year.
- 40% of OTP patients in the United States have been in methadone maintenance treatment for more than two years.[135]

THE QUALITY OF METHADONE MAINTENANCE

As the safety and effectiveness of MM was being reaffirmed, three additional findings in the 1990s triggered efforts to elevate the quality of methadone treatment.[136] The first centered on the scientific studies of Dr. John Ball and his colleagues suggesting that program factors (e.g., program policies, management capabilities, workforce stability, and staff training) play a greater role in MM clinical outcomes than do patient factors.[137] The second was the 1990 General Accounting Office (GAO) report that exposed the high frequency of heroin and other drug use by MM patients as resulting from subtherapeutic doses of methadone.[138] The third factor was growing awareness of the wide variability in quality of MM treatment programs in the United States and the lack of clear standards or guidelines for best clinical practices in MM.[139]

---

134. Parrino, M. (2008). Coordinating methadone treatment providers and policymakers: Lessons learned over 30 years. *Heroin Addiction and Related Clinical Problems*, *11*(1), 43-46.

135. DASIS (2006). *The DASIS Report: Facilities operating opioid treatment programs: 2005*. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Kresina, T.F., Litwin, A., Marion, I., Lubran, R., & Clark, H.W. (2009). United States government oversight and regulation of medication assisted treatment for the treatment of opioid dependence. *Journal of Drug Policy Analysis*, *2*(1), Article 2.

136. M. Parrino, personal communications, February 11, 2010 and March 4, 2010.

137. Ball, J. C. (1994). Methadone maintenance: A reply to the commentaries. *Addiction, 89,* 813. Ball, J. C., & Corty, E. (1988). Basic issues pertaining to the effectiveness of methadone maintenance treatment. In C. G. Leukefeld & F. M. Tims (Eds.), *Compulsory treatment of drug abuse: Research and clinical practice* (NIDA Research Monograph 88, pp. 178-191). Rockville, MD: National Institute on Drug Abuse. Ball, J. C., Corty, E., Petroski, S. P., Bond, H., Tommasello, A., & Graff, H. (1986). Medical services provided to 2,394 patients at methadone programs in three states. *Journal of Substance Abuse Treatment, 3,* 203-209. Ball, J. C., & Ross, A. (1991). *The effectiveness of methadone maintenance treatment.* New York: Springer-Verlag.

138. U.S. General Accounting Office. (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104).

139. M. Parrino, personal communications, February 11, 2010 and March 4, 2010.

The revived scientific orientation and reaffirmation of the clinical effectiveness of MM, and concerns about quality of care across MM programs, led to the formation of a Commission established by the Institute of Medicine[140] to study the Federal regulation of methadone. One of the Study Panel's major recommendations led to the 2001 shift in regulatory authority over MM from the Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) to the Center for Substance Abuse Treatment (CSAT), one of the arms of the Substance Abuse and Mental Health Services Administration (SAMHSA). One of CSAT's first acts was a conceptual shift in the identity of MM from that of the methadone clinic to that of an Opioid Treatment Program (OTP). CSAT supported the independent accreditation of OTPs, refined and disseminated OTP guidelines and best-practices protocol, and provided OTP-related training and technical assistance. The shift from a regulatory oversight model to an accreditation and technical assistance model reflected the desire for greater emphasis on quality improvement and elevated outcomes in MM.[141] Consistent with this quality emphasis, CSAT developed a series of updated Treatment Improvement Protocols (TIPs) related to MM: *State Methadone Treatment Guidelines*, 1993; *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients*, 1994; *Matching Treatment to Patient Needs in Opioid Substitution Therapy*, 1995; *LAAM in the Treatment of Opiate Addiction,* 1995; and *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, 2005.

CULTURAL AND PROFESSIONAL STATUS OF METHADONE MAINTENANCE

Other changes influenced the cultural and professional status of MM. First, there was an increase in public education efforts that portrayed addiction as a treatable brain disease. These noteworthy programs, including the PBS special, *Moyers on Addiction: Close to Home* (1998) and the HBO special, *Addiction* (2007) heightened public awareness of new neurobiological understandings of drug addiction and effective treatments. The educational programming was accompanied by efforts by the American Bar Association Standing Committee on Substance Abuse, Join Together, Legal Action Center, and other organizations to address the stigma and discrimination faced by MM patients[142] and the growing political interest in protecting the rights of MM patients (e.g., work of the Congressional Caucus on Addiction, Treatment and Recovery). Among these efforts was a combined initiative by the American Bar Association and Join Together soliciting testimony about the current state of stigma and discrimination toward those who are addicted, those who have loved ones who are addicted, those in or seeking treatment and recovery, and those who have tried to put addiction behind them only to encounter discrimination based on their history of addiction.

---

140. Institute of Medicine. (1995). *Federal regulation of methadone treatment.* (Richard A. Rettig and Adam Yarmolinsky, Editors). Washington, D.C.: National Academy Press.

141. Parrino, M. (1998). The American Methadone Treatment Association, Inc. (AMTA): The tornado of change. *Journal of Maintenance in the Addictions*, *1*(3), 71-80.

142. Join Together (2003). *Ending discrimination against people with alcohol and drug problems.* Retrieved December 18, 2009 from www.jointogether.org/discrimination.

A second force was the political awakening of people in medication-assisted recovery, as evidenced by the creation of new recovery advocacy groups as well as the inclusion of people in medication-assisted recovery in leadership roles in mainstream recovery advocacy organizations, such as Faces & Voices of Recovery.[143] The medication-assisted groups included Advocates for the Integration of Recovery and Methadone (AFIRM, founded 1995), the National Alliance for Medication Assisted Recovery (formerly the National Alliance of Methadone Advocates, founded 1988), Advocates of Recovery through Medicine (ARM, founded in 1999-2000), and the Opioid Dependence Resource Center. One outcome of this awakening was the growth in patient advisory boards and patient run groups within OTPs, as well as increased representation of MM patients on various federal, state, and local policy committees.

The heightened professionalization of the MM treatment field also served to elevate the status of MM. Such professionalization spanned the evolution of the Northeast Regional Methadone Treatment Coalition (1984) into the American Methadone Treatment Association (1990), the American Association for the Treatment of Opioid Dependence (AATOD, 2001), and the more recent founding of the World Federation for the Treatment of Opioid Dependence (2007). These associations emerged in direct response to the contraction of publicly funded methadone treatment and public attacks on methadone maintenance (e.g., the 1983 "Deadly Cure" series in the *South Florida Sun-Sentinel*). The drive to both defend and elevate the quality of MM contributed to the transformation of "methadone clinics" into "Opioid Treatment Programs" (OTPs), the development of OTP accreditation standards, and the subsequent accreditation of all 1,215 OTPs in the United States.[144]

These achievements co-exist with regressive forces that continue to tarnish the image of methadone as a medication, methadone treatment patients, and America's OTPs. In spite of scientific and professional advancements, cultural stigma and professional and political hostility toward methadone maintenance continue.[145]

RECOVERY-ORIENTED METHADONE MAINTENANCE

There is growing interest in recovery-oriented OTPs in the U.S. In 2005, the National Quality Forum (NFQ), through support from the Robert Wood Johnson Foundation and the Center for Substance Abuse Treatment, created national standards for addiction treatment that called for treating persons with severe substance use disorders via a "chronic care model" focused on long-term

143. Woods, J. (1997). Advocacy and making change: The voice of the consumer. In J. H. Lowinson, P. Ruiz, R. B. Millman, & J. Langrod (Eds.), *Comprehensive textbook of substance abuse* (3rd edition, pp. 865-873). Baltimore, MD: Williams and Wilkins.

144. M. Parrino, personal communications, February 11, 2010 and March 4, 2010.

145. Clark, H.W. (2010). Pennsylvania may limit methadone treatment to one year. *Alcoholism & Drug Abuse Weekly*, 22(25), 4-6.

recovery management support. The NFQ further supported the availability of integrated pharmacotherapy and psychosocial treatment for all adults diagnosed with opioid dependence. Efforts are underway to move beyond harm reduction toward an enhanced recovery orientation[146] and to conceptually and clinically bridge medication-based strategies aimed at reduction of personal and social harm and psychosocial models of addiction treatment.[147] Proponents argue that these efforts to bring dichotomized approaches into an integrated framework are particularly promising because they provide a means of working with individuals at different stages of their addiction and recovery careers. The New York State Office of Alcoholism and Substance Abuse Services (OASAS) is working to transform its methadone clinics into comprehensive addiction recovery centers offering multiple levels and modalities of care. In New York, a peer-based recovery support services model was developed in 2006 for patients in methadone treatment via the CSAT-funded Recovery Community Services Program. The Medication Assisted Recovery Services (MARS) project in New York City is likely to be widely replicated.[148]

In 2009, Southwest Behavioral Health Management, a large behavioral health management organization in Pennsylvania, and the Institute for Research, Education and Training in the Addictions (IRETA) developed the first recovery-focused practice guidelines for methadone maintenance treatment.[149] Other evidence of the movement toward a recovery orientation in OTPs includes the number of recovery-themed plenary presentations at the 2009 AATOD annual conference and the growing number of OTPs and recovery advocacy organizations providing Methadone Anonymous meetings. The Center for Substance Abuse Treatment has also been influential in this movement through its funding of several MM recovery support initiatives, including a new CSAT monograph, Introduction to *Recovery-Oriented Systems of Care for Opiate Treatment.* Also promising are renewed efforts to reduce the cultural and professional stigma that has permeated methadone as a medication, methadone maintenance patients, and methadone maintenance treatment providers.[150]

These broad initiatives are influencing particular aspects of recovery-oriented service practice within MM. Some of the more promising of these include:

- **Recovery Representation:** OTPs are attempting to increase recovery representation at board, leadership, staff, and volunteer levels, e.g., growing interest in consumer councils and other patient-centered advisory and governance structures.[151]

146. Rabinowitz, A. (2009). Enhancing medication-assisted treatment: Success beyond harm reduction. *Journal of Social Work Practice in the Addictions*, *9*, 240-243.

147. Kellogg, S.H. (2003). On "Gradualism" and the building of the harm reduction-abstinence continuum. *Journal of Substance Abuse Treatment*, *25*, 241-247. Kellogg, S.H., & Kreek, M.J. (2005). Gradualism, identity, reinforcements, and change. *International Journal of Drug Policy*, *16*, 369-375. McLellan, A.T. (2003). What's the harm in discussing harm reduction: An introduction to a three-paper series. *Journal of Substance Abuse Treatment*, *25*, 239-240.

148. Ginter, W. (2009). *Advocacy for medication-assisted recovery.* Retrieved November 4, 2009 from http://www.facesandvoicesofrecovery.org/publications/profiles/walter_ginter.php.

149. Institute for Research, Education and Training on Addictions (IRETA). (2010). *Recovery-oriented methadone: Improving practice to enhance recovery* (Report prepared for Southwest Behavioral Health Management, Inc.). Pittsburgh, PA: IRETA.

150. White, W. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

151. 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.*

- **Recovery-Linked Quality Indicators**: Substantial progress is being made in meeting consensus guidelines for methadone treatment, e.g., increases in the percentage of OTPs using optimal methadone dosages, increased retention/duration of participation in OTPs, and HIV testing, counseling, and outreach.[152]
- **Patient Choice:** There is increased emphasis on the importance of patient participation in decision-making within OTPs.[153] The introduction of buprenorphine as an alternative medical treatment for opioid dependence via the 2002 approval of Subutex® and Suboxone® is also giving patients additional medication and delivery site options, although this is severely limited due to its cost.[154]
- **Service Relationship:** There is growing interest in elevating the quality of service relationships in OTPs—relationships free of contempt and grounded in a sustained partnership marked by respect, emotional authenticity, and continuity of support. MM advocates are calling for a reaffirmation of the MM patient's status to that of a "patient" whose concerns are heard rather than an addict whose every complaint represents "drug seeking behavior" and who must be controlled in a paternalistic fashion.
- **Peer-Based Recovery Support:** There are new experiments with MM-specific approaches to peer-based recovery support services, improved relationships between OTPs and existing recovery mutual aid groups, development of new medication-assisted recovery support groups, and development of assertive procedures for linking MM patients to mutual aid groups and other recovery community institutions. Patients who daily stand in the queue to receive their dose of methadone have little contact with highly stabilized and high functioning MM patients in recovery, and few patients beginning MM treatment know of former MM patients who have tapered from MM and successfully sustained long-term recovery. What they do see are the least stabilized patients as well as patients who are returning to MM following earlier post-treatment relapse; they see neither successful long-term maintenance nor sustained recovery after medication maintenance.[155] The goal of OTP-based or -linked peer-based recovery support services is to offer living proof of long-term medication-assisted recovery and the variation in styles of such recoveries.

---

152. Stocker, S. (2000). Drug abuse treatment programs make gains in methadone treatment and HIV prevention. *NIDA Notes*, *15*(3), 1-2.

153. Stocker, S. (2000). Drug abuse treatment programs make gains in methadone treatment and HIV prevention. *NIDA Notes*, *15*(3), 1-2.

154. D'Aunno, T., & Pollack, H.A. (2002). Changes in methadone treatment practices: Results from a national panel study, 1988-2000. *Journal of the American Medical Association*, *288*(7), 850-856.

155. Rosenbaum, M., & Murphy, S. (1984). Always a junkie?: The arduous task of getting off methadone maintenance. *Journal of Drug Issues*, *14*, 527-552.

- **Alternative Frameworks for Recovery Maintenance Support:** Early pilots of medical maintenance—medication maintenance via a monthly visit to a physician's office—hold great promise as a support option for highly stabilized patients.[156] Medical maintenance represents a means of nesting recovery within each patient's natural environment as well as a means of more completely severing ties with the drug culture.
- **Post-treatment Monitoring, Support, and Early Re-intervention:** Regardless of the theoretical orientation underlying MM, the reality is that few MM patients are continuously enrolled in MM for life. In 2005, the average time in treatment for patients discharged from opioid replacement therapy in the United States was 245 days.[157] Models of sustained post-treatment recovery checkups and outreach-based re-intervention with disengaged MM patients are available for wide replication and adaptation, to support the ongoing treatment and recovery of these patients.[158]

We will explore recovery-oriented service practices in great detail in the third article in this monograph. There are significant but not insurmountable challenges to achieving greater recovery orientation within OTPs. The cultural and professional climates remain hostile toward MM. Patients and service providers were reminded of this when public billboards proclaiming "Methadone Kills" appeared across the country in 2008. Attacks on MM from other addiction treatment professionals continue amidst allegations of financial profiteering by MM clinics and tort lawyers who view OTPs as a new source of potential plunder. Like that of other addiction services, public funding of MM is precarious in these difficult financial times because of municipal and state budget crises. Also, third-party payors (private and public insurance) are exerting an ever greater influence on MM through their decisions regarding what MM-related services they will and will not pay for, and for how long.

Acknowledging such challenges does not imply that OTPs lack ownership of their own fate. The future of OTPs will rest primarily on their own collective ability to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of education and political/professional influence. The degree of success of such campaigns will determine the safety and quality of MM as a person-centered, recovery-focused medical treatment. It will also determine the future of the "peculiar American ambivalence about the opioid addict as not quite a patient and not quite a criminal."[159]

---

156. Novick, D.M., & Joseph, H. (1991). Medical maintenance: The treatment of chronic opiate dependence in general medical practice. *Journal of Substance Abuse Treatment, 8*, 233-239. Novick, D.M., Joseph, H., Salsitz, E.A., Kalin, M.F., Keefe, J.B., Miller, E.L., & Richmond, B.L. (1994). Outcomes of treatment of socially rehabilitated methadone patients in physicians' offices (medical maintenance): Follow-up at three and a half to nine and a fourth years. *Journal of General Internal Medicine*, *9,* 127-130. Senay, E.D., Barthwell, A.G., Marks, R., Bokos, P., Gillman, D., & White, R. (1993). Medical maintenance: A pilot. *Journal of Addictive Diseases*, *12*(4), 59-76.

157. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from Substance Abuse Treatment Services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

158. 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. Zanis, D. A., McLellan, A. T., Alterman, A. I., & Cnaan, R. A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry*, *153*, 1095-1096.

159. Jaffe, J., & O'Keefe, C. (2003). From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence, 70,* S3-S11.

SUMMARY

Methadone maintenance as originally conceived and practiced constituted one of the few treatments based explicitly on an understanding of addiction as a chronic disease. The original model of MM posited that full recovery from, but not a cure of, heroin addiction was possible and that such recoveries were best nourished within a supportive and service-rich treatment milieu marked by a sustained recovery support partnership between MM staff and their patients. Throughout the 1970s and 1980s, many core beliefs and practices of MM programs changed in ways that eroded their personal recovery orientation, the scope of services offered, and their overall effectiveness (as measured by attraction, retention, and personal recovery outcomes). The work to revitalize today's OTP programs in the United States and to recapture their focus on long-term recovery should be welcomed by all addiction professionals.

The OTP system of care in the United States may itself be in need of a recovery process. This would involve acknowledging that, as a system of care, OTPs have lost their recovery orientation, and that patients are being harmed in some OTPs by sub-standard services and by service milieus that fail to visibly model and nurture long-term personal and family recovery. The gross power inequities between the patient and clinic must be acknowledged, abuses of such power admitted, and new service relationships forged on a long-term recovery partnership model. Substandard care must be exposed and confronted, amends must be made where possible, and OTPs must be transformed into recovery-oriented systems of care.

In the next two articles, we will attempt to lay a foundation for such systems-transformation processes by defining recovery within the context of methadone treatment (and the broader arena of medication-assisted treatment) and discussing strategies of sustained recovery management in the OTP context.

II. Recovery and Methadone

William L. White, MA
Lisa Mojer-Torres, JD

> *Essentially the question is whether the emphasis in treatment should be directed to the patient or to the medication.*
>
> *—Dr. Vincent Dole*[160]

> *I am not my disease, and I am not my medication.*
>
> *—Excerpt from methadone patient's email to the authors, 2009*

> *The only places my recovery is known of and respected is at my MMTP and among my family. To others, my recovery remains nonexistent, it's a part of my life I sometimes feel ashamed of, not because of my ignorance, but that of others. I have worked hard over the years to achieve my optimal dose stabilization & to sustain my recovery.*
>
> *—Excerpt from methadone patient's email to the authors, 2010*

The use of medications such as methadone, naltrexone, and Buprenorphine/Suboxone/Subutex in the treatment of opioid addiction, and questions related to the recovery status of patients taking these medications, continue to be debated vigorously at professional and cultural levels. Such discussions have intensified in tandem with recent efforts in the United States and the United Kingdom to define recovery from substance use disorders and with the emergence of recovery as a central organizing construct for the addictions field and the larger arena of behavioral health care.[161]

Can a methadone patient who has achieved long-term dose stabilization, uses no other non-prescribed opioids or other intoxicants (including alcohol), and has achieved significant improvements in psychosocial health and positive community integration be considered *in recovery* or *recovering*? The authors offer a clear, affirmative answer to that question as we outline 24

160. Dole, V.P. (1973). Detoxification of methadone patients, and public policy. *Journal of the American Medical Association*, *226*(7), 780.

161. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. Center for Substance Abuse Treatment (CSAT). (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration. Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 221-228. United Kingdom Drug Policy Commission. (2008). A consensus definition of recovery. Accessed June 24, 2010 at http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf . White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241. White, W. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

propositions related to the role of methadone maintenance in long-term addiction recovery, propositions that we believe are supported by the available historical, scientific, and clinical evidence.

METHADONE AND RECOVERY STATUS

1. **Productive explorations of the effects of methadone or other medications on addiction recovery status hinge on a clear definition of recovery.**
2. **The recovery status of methadone maintenance (MM) patients should be evaluated using the same definition of recovery that applies to the resolution of all substance use disorders.**

Controversy and stigma continue to surround the use of methadone in the treatment of opioid addiction, in spite of more than four decades' worth of scientific evidence of its effectiveness. Methadone patients continue to be socially marginalized, and their recovery status is debated even within the professional field of addiction treatment and various recovery communities. Answering the controversy regarding the recovery status of methadone patients requires a clear understanding of what constitutes recovery from opioid addiction. Recovery from opioid addiction and other substance use disorders is a historically ill-defined concept that is often viewed differently by policymakers, the public, addiction and allied health professionals, and affected individuals and families.

RECOVERY AS INTENTION

3. **Public understanding of addiction *recovery* as a motivational state rather than a stable behavioral health status contributes to therapeutic pessimism and the social stigma attached to addiction and addiction treatment.**
4. **Recovery is more than "trying" to decelerate or stop opioid and other drug use. The "trying" definition sets a low bar for expectations related to global health and functioning, contributes to the stigma attached to methadone treatment, and restricts opportunities for the methadone patient to participate positively in community life.**

When Faces & Voices of Recovery commissioned a survey of how the American public understood the word "recovery," one of the findings was particularly surprising. The majority of those

surveyed thought the term recovery referred to someone who was "*trying* to stop using alcohol or drugs."[162] Bombarded by daily scenes of celebrities heading back to "rehab," the public has come to see recovery as a fragile motivational state rather than as the durable experience of the millions of individuals in the U.S. who are in stable long-term addiction recovery.[163]

The understanding of recovery as intention shapes differing views of MM based on how the public perceives methadone and motivations for its use. If methadone is viewed as an intoxicating drug (a "legal high") and patient motivation for MM is viewed as a search for intoxication, then MM patients will not be afforded recovery status due to their failure to meet the "trying to stop" criterion. If, on the other hand, methadone is viewed as a non-intoxicating, normalizing medication taken by MM patients to promote social rehabilitation and eliminate the symptoms that lead to drug-seeking, MM might well be embraced within the public's current conception of recovery. The danger even in this latter scenario is that the bar for recovery would be set so low that those achieving it would still be stigmatized and estranged from mainstream community life.

RECOVERY AS REMISSION

5. **Recovery is more than remission (defined as the sustained cessation or deceleration of drug use/problems to a point at which the person no longer meets diagnostic criteria for opioid dependence or another substance use disorder).**
6. **Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of personal/family life.**

Remission is a clinical term used in psychiatry and addiction medicine to convey that the diagnostic elements for a substance-related disorder have diminished completely (key symptoms no longer present) or partially (presence of some symptoms, but not sufficient in number or severity to meet diagnostic criteria).[164] If recovery is defined as remission, then the primary measure of recovery is not abstinence from drug use but the absence of drug-related clinical pathology. This approach is reflected in opioid addiction treatment outcome studies that have defined recovery as a state in which "drug abuse and related behavior are no longer problematic in the individual's life."[165] Simpson and Marsh,[166] for example, define recovery from opioid addiction in terms of the indicators of "reduction of drug use, criminal involvement and unemployment"—a definition that does not explicitly require abstinence from heroin or other drugs.

---

162. Peter D. Hart Research Associates. (2004). *Faces and Voices of Recovery Public Survey*. Washington, D.C.: Peter D. Hart Research Associates.

163. Compton, W.M., Thomas, Y.F., Stinson, F.S., & Grant, B.F. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States. *Archives of General Psychiatry, 64*(5), 566-576. Dawson, S.A., Grant, B.F., Stinson, F.S., Chou, P.S., Huang, B., & Ruan, W.J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction, 100*(3), 281-292. Hasin, D.S., Stinson, F.S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 64*(7), 830-842. . . . .

164. American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

165. Leukefeld, C.G., & Tims, F.M. (1986). Relapse and recovery: Some directions for research and practice. In F. Tims & C. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Monograph 72, pp. 185-190). Rockville, MD: National Institute on Drug Abuse. . . . .

166. Simpson, D.D., & Marsh, K.L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. Tims & C. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Monograph 72, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

Some MM advocates have argued that MM treatment should be evaluated by one criterion only: its ability to bring heroin dependence into stable remission.[167] Others have argued against the recovery-as-remission definition.

> *… cultural and professional misunderstandings and stigma attached to methadone led to justifications of MM that focused on what methadone could* ***subtract*** *from an addicted individual's life in terms of crime and broader threats to public safety and health. It is time we told the story of what the use of methadone and other medications combined with comprehensive and sustained clinical and recovery support services can add to the quality of life of individuals, families and communities.*[168]

> *As long as well-intentioned people go around saying that "methadone is recovery," it is going to continue to be misunderstood. Methadone is a medication, a tool, even a pathway, but it is not recovery. Recovery is a way of living one's life. It doesn't come in a bottle.*[169]

When recovery is defined solely in terms of remission, stabilized MM patients who are no longer addicted to opioids meet the criteria for achieving the status of recovery without accounting for other drug (including alcohol) use patterns or whether or not they have achieved larger improvements in quality of life and social functioning.

The American Society of Addiction Medicine has taken a step beyond the recovery-as-remission definition by defining recovery as "overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety."[170] ASAM added the criterion of intentionality via a commitment for future sobriety, perhaps to distinguish recovery from the artificially imposed periods of enforced abstinence that are often part of prolonged addiction careers. Based on this definition, the stabilized person in MM who is no longer addicted to heroin *and* who is committed to continued abstinence from heroin would meet this definition of recovery. One weakness of the ASAM definition is that it doesn't specify what other kinds of drug use would fall outside the boundaries of this definition of sobriety.

---

167. Newman, R.G. (1991). What's so special about methadone maintenance? *Drug and Alcohol Review*, *10*, 225-232.

168. White, W. (2009a). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

169. W.Ginter, personal communication, June 22, 2009.

170. American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance use disorders* (2nd Ed.). Chevy Chase, MD: ASAM.

RECOVERY AS ABSTINENCE

7. **Recovery from opioid addiction is more than the removal of drug use from an otherwise unchanged life.**
8. **Optimum, individualized doses of methadone do not produce intoxication in stabilized MM patients; as such, methadone prescribed under these circumstances should be viewed as a medication rather than a "drug."**
9. **Methadone pharmacotherapy enhances rather than interferes with the reduction/cessation of drug use and the broader processes of psychosocial rehabilitation.**

The predominant abstinence orientation of addiction treatment in the United States is reflected in abstinence-based treatment goals and in reporting treatment follow-up studies in terms of the percentage of patients who have been continuously abstinent since discharge or abstinent at the time of follow-up—abstinence here referring to abstinence from the substance(s) to which the patient was once addicted. Recovery as abstinence is also reflected in the use of "sobriety birthdays" and "clean time" within recovery mutual aid groups. Recovery as the cessation of all "alcohol and other drug use" is similarly the centerpiece of the anti-stigma messaging campaigns of recovery advocacy organizations.[171] Historically, a broad spectrum of addiction professionals and recovery community leaders have posited concepts such as "dry drunk," "mental sobriety," "emotional sobriety," "wellbriety," and "stage II recovery"[172] to convey that addiction recovery is more than the absence of drug use. Yet the question remains, "Does the use of methadone as a medication violate the abstinence requirement that many would posit as a component of addiction recovery?" Answering that question involves two related questions.

The first of these questions is: Does the consumption of a medically supervised, optimum oral dose of methadone by the stabilized MM patient produce intoxicating effects? Or put another way, "From the standpoint of recovery status, should methadone used in these circumstances be viewed as equivalent to the use of heroin or other intoxicants?" The anti-methadone stance within NA has at its roots the experiential knowledge of many NA members who used methadone as an intoxicant during their addiction careers, who used MM for purposes other than recovery, who jockeyed for high methadone doses and combined those doses with other drugs for purposes of intoxication, and who had little if any contact with highly stabilized, high-functioning MM patients. Through the lens of that experience, it is easy to see methadone as just another drug and any methadone use as precluding status as a person in recovery. But there is another side to this story.

---

171. Faces and Voices of Recovery (2006). *New messaging from Faces & Voices of Recovery: Talking about recovery.* Retrieved January 5, 2010 from http://www.facesandvoicesofrecovery.org/publications/recovery_messaging/about_recovery.php.

172. For a review, see White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

Stabilized doses of methadone that are individualized, optimal, and ingested orally as a medication in MM do not usually produce euphoria in stabilized patients. For most patients, the tolerance to methadone resulting from prolonged daily administration of optimum dosages neutralizes the potentially intoxicating properties of the medication and other opioids when properly administered.[173] Three pioneers of MM in the United States—Drs. Mary Jeanne Kreek, Ed Senay, and Robert DuPont—elaborate on this point:

> *When initial methadone treatment doses are appropriately chosen and then increased at a sufficiently slow rate so that tolerance develops following each increment, no narcotic-like effects should be perceived by a patient in methadone maintenance treatment.*[174]
>
> *There are sedating and intoxicating doses of any opioid, methadone included, but in a well-run clinic one does not see sedation or intoxication because dose effects are monitored and therapy deals with the issue of intoxication [from other substances].*[175]
>
> *A patient receiving a stable, once-a-day oral dose of methadone is not intoxicated or impaired by the methadone because of virtually complete tolerance to the sedating effects of the medication. For patients taking stable daily oral dosages of methadone, the effect is the functional equivalent of a depressed patient taking a daily dose of Prozac. However, when that same dose of methadone is injected intravenously, it elicits an equivalent "brain reward" as would be experienced with injected heroin or Oxycodone. For the nontolerant person—a person who has not taken a stable oral dose of methadone for days, weeks or longer—the commonly prescribed methadone dosages are intoxicating and often fatal. MM patients who exhibit signs of intoxication or sedation while taking a therapeutic dose of methadone have either not yet achieved dose stabilization (usually during the induction period or when the dose is raised significantly), or they are exhibiting signs of other recent alcohol or other drug use. Any methadone patient showing signs of impairment needs to be promptly evaluated: intoxication and impairment are not an expected part of the therapeutic experience of methadone treatment.*[176]

---

173. Dr. Vincent Dole did note the rare patient who failed to develop full tolerance to the sedating effects of methadone. Cushman, P., & Dole, V.P. (1973). Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association*, *226*(7), 747-752. Newman, R.G. (1991). What's so special about methadone maintenance? *Drug and Alcohol Review*, *10*, 225-232.

174. Kreek, M.J. (1993). Epilogue: A personal retrospective and prospective viewpoint. In M.W. Parrino, *State methadone treatment guidelines Treatment Improvement Protocol Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

175. Senay, E.C. (1985). Methadone maintenance treatment. *International Journal of the Addictions*, *20*(6&7), 803-821.

176. R. DuPont, personal communication, February 17, 2010.

The second question is: Does the use of methadone aid or hinder the broader processes of psychosocial rehabilitation? Early tests of MM found that patients who had achieved effective dose stabilization were "functionally normal"[177] and that methadone did not interfere with mental or physical performance.[178] Continued participation in MM in spite of problems related to such participation (e.g., medication side-effects in some patients; limitations on education, work, and travel; social stigma) reflects the positive stability that MM offers and the experience of relapse to heroin that patients often experience following cessation of MM. MM studies consistently report decreased death rates (as much as 50%); reduced transmission of HIV, Hepatitis B and C, and other infections; and improvements in global health and social functioning.[179]

In spite of this evidence, many MM patients experience sustained pressure to end methadone maintenance.

> *There is a constant theme experienced daily by MM patients—that they must be lowering their dose and proceeding toward detoxification. Only total abstinence from methadone is considered a methadone success story. The PA [physician's assistant] who runs my program said to me at my physical last year that he "thought I'd be off this stuff" by now… In his eyes, I'm not a success because I am still on methadone. If the people who literally dispense methadone don't view it in terms of recovery or even as medication, how can the patients?* [180]

The professional controversies over the question of methadone, abstinence, and recovery status are well illustrated in the debate surrounding a study by Maddux and Desmond.[181] The authors conducted a study to determine if MM prolonged addiction careers—defined as the time period from onset of drug use to achievement of sustained abstinence, with *abstinence* defined as also terminating the use of methadone as a medication. Dr. Robert Newman challenged this definition:

> *We do a disservice to methadone maintenance programs and their patients by suggesting that "completion" of treatment and subsequent abstinence are the sine qua non of therapeutic success in the treatment of opioid dependence.*[182]

Newman further argued that recovery should be understood solely in terms of "cessation of heroin use, sharply reduced morbidity and mortality, and restoration of the ability to lead a productive and self-fulfilling life."[183]

---

177. Dole, V.P., & Nyswander, M.E. (1965). A medical treatment for diacetylmorphine (heroin) addiction. *Journal of the American Medical Association*, *193*, 646-650. Dole, V.P., & Nyswander, M.E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

178. Gordon, N.B. (1973). The functional status of the methadone maintained person. In. L.R.S. Simmons & M.B. Gold (Eds.), *Discrimination and the addiction* (pp. 101-123). Thousand Oaks, CA: Sage.

179. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

180. Methadone patient email to the authors, June, 2010.

181. Maddux, J.F., & Desmond, D.P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74. Maddux, J.F., & Desmond, D.P. (1992). Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, *18*(3), 289-303.

182. Newman, R.G. (1993). Methadone maintenance and recovery. *American Journal of Drug and Alcohol Abuse, 19*(1), 135-137.

183. Newman, R.G. (1993). Methadone maintenance and recovery. *American Journal of Drug and Alcohol Abuse*, *19*(1), 135-137.

Dr. Vincent Dole, co-developer of MM, was similarly critical of definitions of recovery that focused narrowly on abstinence without regard to health and social functioning:

> *"… methadone patients are not necessarily committed to a lifelong dependence on the medication… The key to this result [sustained abstinence following termination of methadone maintenance] is the realization that the most important objective in treatment of an addict is support of good health and normal function. This may or may not require continuation of maintenance. An obsessive preoccupation with abstinence is self-defeating, leading to low-dose programs (which fail to stabilize the patient), premature discharge from treatment and low self-esteem if long-term abstinence seems unattainable… Available data suggest that the longer a patient continues in a maintenance program that provides adequate doses (e.g., five years or more), the greater his or her probability of permanent abstinence after termination of treatment… the neurochemical adaptations produced by thousands of heroin injections… are capable of gradual repair in some cases under the steady conditions of methadone maintenance.*[184]

Subsequent studies have confirmed Dole's contention that higher methadone doses are linked to greater reductions in illicit opioid use than lower doses.[185]

Cessation of methadone use as a requirement for recovery status is contradicted by research linking methadone dose stabilization to decreased drug use and increased global health, and cessation of MM to increased risk for clinical deterioration, resumption of heroin use, and death. Dole argued that there was no medical evidence that the majority of MM patients could be completely tapered from methadone without compromising recovery stability and that "the question of whether and when to discontinue methadone therapy can be answered in medical terms if the treatment is judged by the same standards as apply to other chronic diseases."[186]

There are recent efforts to explicitly define abstinence in the MM context and to abandon use of "abstinence" and "drug free" as a treatment program designation, as was recently recommended by the Clinical Training Program Caucus (NIDA's Clinical Trials Network):

> *We are writing to recommend that NIDA retire the terms "abstinence-based" and "drug free" to refer to programs that do not use or permit the use of methadone. At best, these terms are confusing, and at worst, they perpetuate the stigma against*

184. Dole, V.P. (1994). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

185. Strain, E.D., Bigelow, G.E., Liebson, I.A., & Stitzer (1999). Moderate- vs. high-dose methadone in the treatment of opioid dependence. *Journal of the American Medical Association*, *28*(11), 1000-1005.

186. Dole, V.P. (1973). Detoxification of methadone patients, and public policy. *Journal of the American Medical Association*, *226*(7), 781.

methadone patients and treatment providers. "Abstinence" no longer precludes the appropriate use of prescribed medications. "Drug free" refers to patients who are no longer using illicit drugs…We do not suggest that someone on Prozac is not abstinent, so why do so with methadone? A methadone patient is abstinent if he/she is not using alcohol or illicit drugs, and is using legal ones as prescribed. This definition is accepted within the methadone treatment community, and is consistent with the stance that appropriately prescribed medication is compatible with recovery. Clinging to the obsolete terms perpetuates the stigma of methadone as something less noble than other treatments by suggesting that success is measured by the discontinuation of opioid agonist medication. Some patients and providers have internalized this stigma, to their detriment.[187]

RECOVERY AS GLOBAL HEALTH AND FUNCTIONING

10. **Recent attempts to define addiction recovery have focused on three essential elements: a) the resolution of drug-related problems (most often measured in terms of sobriety/abstinence or diagnostic remission), b) improvement in global health, and c) citizenship (positive community reintegration).**
11. **MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the methadone.**
12. **The stabilized methadone maintenance patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners meets the first criterion for recovery.**
13. **Physical dependence on a medication and drug addiction are not the same: like many pain patients maintained on opioid medications, the stabilized methadone maintenance patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners does not meet key definitional criteria for addiction (e.g., obsession with using, loss of volitional control over use, self-accelerating patterns of use, compulsive use in spite of adverse and escalating consequences).**

There is growing consensus across historical, cultural, and professional contexts that recovery from severe alcohol and other drug problems includes more than the subtraction of these sub-

187. J. Zweben, personal communication, February 5, 2010.

stances from one's life. In 2007, the Center for Substance Abuse Treatment hosted a Recovery Summit in which participants defined recovery from alcohol and drug problems as *"a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life."*[188] That same year, the Betty Ford Institute published a recovery definition drawn from a consensus conference of addiction researchers, addiction treatment professionals, and people in recovery. Conference members defined recovery from substance dependence as *"a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."*[189] The issue raised in these definitions that is most relevant to this monograph is whether stabilized methadone maintenance patients are embraced within or excluded from the meaning of abstinence and sobriety.

Methadone recovery status is at the center of evolving and conflicting perceptions of methadone use (recovery-enhancing medication versus addictive drug). It profoundly influences the lives of potential, current, and past MM patients who see attitudes toward methadone revealed in the:

- cultural/professional equation of methadone and heroin (e.g., the claim that MM just substitutes one addicting drug for another—an equation reinforced by the characterization of MM *as replacement therapy or substitution therapy*);
- pressure experienced by MM patients from family members to stop MM treatment;
- prohibition against having an MM patient speak at a meeting, lead a service committee, or receive a sobriety chip within many local Narcotics Anonymous groups;
- refusal on the part of addiction treatment programs and recovery support institutions that do not use medications to admit MM patients in need of their services or to refer their own patients who could benefit from adjunctive, medication-assisted treatment;
- within MM clinic cultures, stigmatization of patients on higher methadone dosages;
- pressure from counselors for patients to terminate MM;
- the discrimination MM patients experience in such arenas as education, employment, housing, health care, and government benefits; and
- ultimata issued by family members and drug court judges who order the parents/defendants to taper methadone intake or leave methadone maintenance treatment as a condition of retaining child custody or visitation rights, or as a condition of probation.[190]

188. Center for Substance Abuse Treatment (CSAT). (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

189. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228.

190. White, W. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

Such attitudes and overt acts of discrimination can leave even the most stable and healthiest of MMT patients hiding their "dirty little secret."[191]

The Betty Ford Institute (BFI) Consensus Panel specifically addressed the question of Opioid Treatment Program (OTP) medications and recovery status by defining recovery in terms of sobriety, global health, and citizenship, and then by clearly stating that:

> *… formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety.*[192]

This declaration, coming from one of the institution most often associated with mainstream 12-Step-infused addiction treatment in the United States, stands as a historical milestone in the addiction treatment field's (and this country's) perception of methadone maintenance.

A variant of the Betty Ford Institute definition moves beyond remission and intention by defining long-term recovery as "an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety)."[193] The first of these criteria is synonymous with the medical definition of remission-symptom reduction/elimination to subclinical levels that might or might not include complete abstinence. Criteria two and three create additional inclusion/exclusion measures that focus on the assertive management of collateral problems (e.g., secondary drug dependencies, co-occurring medical and psychiatric illnesses) in tandem with improvements in multiple areas of life functioning and a reconstruction of the person-to-family/community relationship. The added criteria place emphasis on quality of personal and family life and social contribution in long-term recovery.

Within this broader conceptualization of recovery, the question becomes how methadone as a medication, and the realities of the lived experience of methadone maintenance treatment, might enhance or inhibit the fulfillment of each of these three criteria. For example, methadone as a medication could provide a foundation for patients' achievement of all three of the above criteria, while the rigorous demands of MM treatment within the existing clinic system might actually interfere with criteria two and three, e.g., inhibit one's ability to pursue education, full-time employment, financial independence, family responsibilities, home ownership, community service,

---

191. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition* (Unpublished doctoral dissertation). City University of New York. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264.

192. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. McLellan, A.T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment*, *38*, 200-201.

193. White, W. (2009c). *The recovery paradigm and the future of medication-assisted treatment.* Plenary Remarks: American Association for the Treatment of Opioid Dependence, Inc. Conference, New York City, April 28, 2009.

travel, and leisure. Definitions of recovery that address issues of quality of personal/family life will, when applied to the MM patient, need to disentangle methadone as a medication from the lifestyle constraints imposed by MM treatment.

Consistent with Newman's and Dole's views are definitions of recovery that focus on health and functionality without reference to cessation of medical use of methadone. The examples below illustrate such definitions:

> *Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.*[194]
>
> *Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles.*[195]
>
> *The process of recovery from problematic substance use is characterised by voluntary sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.*[196]

Stabilized MM patients would meet these criteria for recovery if they were demonstrating progress toward increased health and functionality. The "sustained control over substance use" in the UK recovery definition is broad enough to include multiple pathways of alcohol and other drug (AOD) problem resolution—traditionally defined abstinence, decelerated patterns of AOD use that no longer meet criteria for a substance use disorder, and medication-assisted recovery—as long as the other criteria of health and positive community participation are met. Similar in spirit to the UK definition were suggestions to the authors from some methadone patients that a broadened definition of recovery is needed.

> *The only way we will ever be able to move addiction treatment to a chronic disease model is if we take the "abstains from alcohol and other intoxicating drugs" our of the recovery definition, or at least stop making it the deciding factor*

194. Recovery Advisory Council, Philadelphia, PA 2005, Department of Behavioral Health and Mental Retardation Services.

195. Anthony, W.A., Rogers, E.S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. Community Mental Health Journal, *39*(2), 101-114.

196. United Kingdom Drug Policy Commision. (2008). A consensus definition of recovery. Accessed June 24, 2010 at http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf .

for the status of being "in recovery"… I think we need to make it one of many goals rather than the focus. This would help us achieve the focus of every other chronic disease treatment: QUALITY OF LIFE and the reduction of symptoms… We have got to stop thinking of recovery as ALL or NOTHING."

THE AMBIGUOUS IDENTITY OF THE MM PATIENT

14. **Denying "abstinence" or "drug free" status to stabilized MM patients (who do not use alcohol or illicit drugs and who take methadone and other prescribed drugs only as indicated by competent medical practitioners) inhibits rather than supports the long-term recoveries of MM patients.**
15. **For stabilized MM patients, continued methadone maintenance and successful tapering from methadone maintenance represent two varieties/styles of recovery experience, not the line of demarcation between addiction and recovery initiation.**
16. **The highly stabilized MM patient is caught in an ambiguous world, separated from cultures of active drug use, denied full membership in cultures of recovery, and socially stigmatized in the larger community.**
17. **It is time that MM patients who meet the three-part recovery definition were welcomed into full membership in the culture of recovery and offered opportunities to pursue full citizenship in their local communities.**

The widely varying definitions of recovery and the role of methadone as a disqualifying, qualifying, or neutral influence in determining recovery status is more than just a theoretical issue for addictionologists. MM patients live their daily lives amidst conflicting perceptions of methadone and MM patients. Stable MM patients have lost membership and status and have acquired stigma within the cultural world of drug users, where they are more likely to be disparaged for having compromised control of their opioid use by their submission to the MM clinic system. Those who should celebrate the MM patient's budding recovery—family members, friends, acquaintances, co-workers, and even other MM patients—all too often still perceive the patient as "on drugs" and continue to ask when he or she is going to "get off methadone." Seeking shelter within the worlds of addiction treatment and recovery, stabilized MM patients encounter continued indignities that demean the value of their accomplishments—denying their right to speak, denying their right to lead, denying their very recovery status. MM patients are taught by addiction treatment professionals that opioid addiction is a brain disease,

but they are treated through institutional practices as if they were feeble-minded, insane, criminal, or recalcitrant children—treated as people who need control rather than care. MM patients face a wider community environment that defines methadone as "just another drug" and MM patients in terms of their perceived addiction rather than their recovery achievements. It is little wonder that the concept of recovery has had so little value in the ambiguous, conflicted world of the MM patient.

Addiction recovery is often the product of a highly personal synergy of pain and hope. Such catalytic turning points usually involve three complementary processes: ***renunciation*** (what is permanently expelled from one's life—the *recovery from* process), ***retrieval*** (what has been lost through one's addiction career—the *recovery of* process), and ***embrace*** (what is newly drawn into the center of one's life—the *recovery to* process).[197] If recovery for the MM patient involves a renunciation of drugs and the drug culture—a physical, psychological, and cultural escape from addiction and a search for new destinations for healing and hope—in what direction is the MM patient expected to step in order to be welcomed?

> *Positing recovery as a journey of self-transformation, the methadone patient subsists in undetermined space—a hinterland beyond the clearly demarcated identity fissures of "addict" or "recovering addict." In the absence of a proactive recovery culture, the methadone maintenance patient becomes tied to an archetypal "spoiled identity"*[198] *to be managed and governed rather than retrieved, nurtured and healed.*[199]

To speak of recovery for the MM patient requires a world in which that recovery can be firmly nested and nurtured—a world where the ambiguous, fractured identity of the stable MM patient may be healed and made whole.[200] The good news is that such a world may be struggling to emerge in communities across the United States.

THE QUESTION OF FAMILY RECOVERY[201]

18. **Chronic opioid addiction severely wounds family and kinship relationships—wounds that feed the intergenerational transmission of drug-related problems.**
19. **Family recovery involves healing those wounds; reconstructing family roles, rules, and relationships; and enhancing the resistance/resilience/health of all family members.**

---

197. Amplified from: Horvath, A.T. (1998). Recovery of vs. recovery from. (Reflections on statement by Monica Harris). *Smart Recovery® News & Views Newsletter*, April, p. 1.

198. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

199. S. Bamber, personal communication, March 22, 2010.

200. S. Bamber, personal communication, March 22, 2010.

201. We wish to thank Mark Parrino for suggesting the inclusion of this discussion within the paper.

Chronic disorders take an inordinate toll on family life due to their duration, the unpredictable ebb and flow of acute episodes, and their potentially profound effects on functionality. The transformation of family life through the addiction and recovery processes include changes in the family system's boundary permeability, the health and functioning of individual family members, 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).[202] Families must develop their own defense structures to survive the effects of addiction, and the fragility of these defense structures can be threatened by the onset of a recovery process. Some research suggests that the restructuring of family processes in early recovery can be so traumatizing as to threaten the survival of the family as a system.[203]

Family recovery is thus a process of the family surviving the insults inflicted by severe AOD problems as well as the adjustments required for the restoration of individual and family health during the stages of recovery initiation and maintenance. Family recovery also involves reducing the intergenerational risks for substance use disorders. At present, most OTPs do not provide services aimed at reducing these risks, e.g., child-focused prevention or early intervention services, parenting training, or family counseling.

> *My daughter is now 15, but she was just seven when I went into treatment. I was very publicly outed (newspaper stories) as an addict, and I had no idea what to tell her about my addiction, let alone about the methadone treatment. Guidance from my counselor would have been wonderful, and I know it would have done my daughter a world of good to have someone to talk to at that time…* [204]

There are far fewer studies of family and parental functioning of MM patients than of patients in alcoholism treatment, but studies to-date confirm two key findings: 1) family/parental functioning is a significant problem for many MM patients, and 2) family-focused services enhance the health of MM patients, their families, and their children.[205] As recovery re-emerges as an organizing construct within OTPs, involving the family members of MM patients in refining the concept of family recovery and in helping design family-focused recovery support services will be important agendas.

---

202. White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

203. Brown, S., & Lewis, B. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

204. Methadone patient email to authors, June 2010.

205. Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment, 32*(4), 381-390. Dawe, S., Harnett, P. H., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: The Parents Under Pressure Programme. *Drug and Alcohol Review*, *22*(3), 299-307. Grella, C.E., Needell, B., Shi, Y., & Hser, Y-I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, *36*(3), 278-293.

SUMMARY

- The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering.
- Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or Buprenorphine/Suboxone/Subutex) constitute different styles of recovery and should not be framed in categories of inferiority or superiority.
- Rather than a source of disqualification for recovery status, methadone, provided under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized.
- It is unlikely that the recovery status of the MM patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MM patients and their families stand together as a collective witness to offer living proof of the role methadone can play in long-term recovery from opioid addiction.
- There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration.

Social and professional stigma constitutes a major obstacle, if not the obstacle, to methadone-assisted recovery. But these cultural winds are shifting. Scientific breakthroughs related to the neurobiology of addiction and addiction recovery are forcing a re-evaluation of methadone maintenance. Some local recovery mutual aid meetings are welcoming MM patients, and Methadone Anonymous and other medication-assisted recovery mutual aid groups are defining and legitimizing recovery within the MM context, as are new methadone-based peer-recovery support projects such as the CSAT-funded Medication Assisted Recovery Services (MARS) project in New York City operated in conjunction with the Division of Substance Abuse at the Albert Einstein College of Medicine.[206] The 2007 Betty Ford Consensus Panel statement that the MM patient who takes methadone as prescribed and is abstinent from alcohol and other drugs meets the definition of sobriety may well constitute a "tipping point" in the field's understanding of and attitudes toward methadone pharmacotherapy. The leading recovery advocacy organization in the United States

206. W. Ginter, personal communication, June 22, 2009.

(Faces & Voices of Recovery) celebrates diverse pathways of long-term addiction recovery (including medication-assisted recovery), and medication-assisted recovery advocates have been a part of the governing board and committees of Faces & Voices since its inception in 2001. Increased recovery orientation within American OTPs is also evidenced by activities of the American Association for the Treatment of Opioid Dependence, efforts to forge recovery-focused models of MM in Philadelphia and New York State, and the Center for Substance Abuse Treatment's *Introduction to Recovery-Oriented Systems of Care for Opiate Treatment.*

The purpose of this article was to directly address the question: Can a methadone patient who has achieved long-term dose stabilization, uses no other non-prescribed opioids or other drugs (including alcohol), and has achieved significant improvement in psychosocial health and positive community integration be considered *in recovery* or *recovering*? After reviewing multiple definitions of recovery, the authors draw the following conclusion:

> *The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering. Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or Buprenorphine/Suboxone/Subutex) are issues of style of recovery and should not be framed in categories of inferiority or superiority. Rather than a source of disqualification for recovery status, methadone, provided under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized by the addiction treatment community, communities of recovery, and the public. There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration.*

Widespread acceptance of methadone maintenance is contingent upon elevating the quality of MM in the United States and on launching an effective and sustained campaign of professional and community education regarding methadone, methadone maintenance treatment, and methadone-assisted personal and family recovery.[207] As a beginning, it is time that current and former MM patients and their families were invited to fully participate in the design, conduct, and evaluation of such a campaign. It is time all addiction professionals stood with Faces & Voices of

207. White, W. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

Recovery in acknowledging that there are many pathways to recovery and that all are cause for celebration. It is time we as a national body of addiction professionals and recovery advocates fully acknowledged the legitimacy and value of methadone-assisted recovery and welcomed stabilized methadone patients as peers in the American culture of recovery.

We are not saying that all or even most methadone patients are in recovery as defined in this monograph. (The prevalence of recovery within MM patients in the U.S. based on these new definitions of recovery has not been measured.) As a starting point, we are saying that there are methadone patients who meet this definition of recovery and that the percentage of MM patients who meet this definition could be significantly increased with a more recovery-focused approach to MM treatment. It is our further hope that this monograph will stimulate discussion about medication and recovery status and the extent to which new definitions of recovery will help or harm persons in methadone maintenance.

In the next article, we will explore why changes in policies and clinical practices within Opioid Treatment Programs in the United States are needed to enhance long-term recovery outcomes.

III: A Vision Statement

William L. White, MA

Lisa Mojer-Torres, JD

> *If opioid dependence is a career, then therapeutic interventions must be measured in career terms.*[208]

To recap the content of this monograph thus far, the first article reviewed the history of MM through three stages: 1) the personal recovery orientation of the early MM model, 2) a shift in the justification, design, and evaluation of MM toward reduction of social harm during the regulation and mass diffusion of MM across the United States, and 3) recent efforts to recapture and refine a person-centered, recovery-focused approach to MM. This third stage was seen as historically significant for its potential to revitalize and elevate the quality of MM treatment as a medical treatment for opioid addiction.[209]

The second article reviewed multiple definitions of recovery and discussed the question: Can a methadone maintenance patient who has achieved long-term dose stabilization, uses no other nonprescribed opioids or other drugs (including alcohol), and has achieved significant improvement in psychosocial health and positive community integration be considered "in recovery" or "recovering"? We noted that emerging definitions of addiction recovery focus on three essential criteria: 1) the resolution of drug-related problems (defined in terms of sustained sobriety or clinical remission—the patient no longer meets diagnostic criteria for a substance use disorder), 2) progress toward global (physical, mental, emotional, relational, and ontological) health, and 3) positive integration and contribution to the community.[210] Using these criteria, we concluded:

> *The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improved global health and social functioning should be considered to be in recovery or recovering. Rather than a source of disqualification for recovery status, methadone, provided under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids*

208. Senay, E.C. (1985). Methadone maintenance treatment. *International Journal of the Addictions*, *20*(6&7), 803-821.

209. White, W., & Torres, L. (2010a). Recovery-oriented methadone maintenance: I. Historical context.

210. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

> *long-term recovery from heroin addiction and should be so recognized by the addiction treatment community, communities of recovery, and the public.*[211]

We concluded in the first two articles that it was time we as a country and a professional field stopped debating the morality of methadone maintenance and focused our energies instead on elevating the quality of methadone maintenance treatment. In this third article, we will attempt to answer two overlapping questions: 1) How would opioid addiction be treated if we *really* believed that it was a chronic brain disease? 2) How would policies and clinical practices related to MM change if the primary goal of MM treatment were long-term personal recovery—defined as remission of the substance use disorder, improved global health, and community re-integration?

One of the most definitive summaries of best practices in opioid addiction treatment is the Center for Substance Abuse Treatment's *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*.[212] Our intent is not to duplicate this exceptional effort, but to highlight particular clinical and support services that have a clear connection to short- and long-term recovery outcomes. Many of the key issues we address in this monograph were highlighted in CSAT's first Treatment Improvement Protocol[213] on methadone treatment. That TIP set forth a clear vision for the future of methadone maintenance:

> *Methadone maintenance providers will be under greater pressure to offer a richer mix of comprehensive services. Peer support groups will become a permanent part of the treatment system. More medical care will be offered at the clinic site as programs create better primary health care linkages to mainstream medical communities. Vocational referral and job placement will become more critical treatment components… More programs will begin to address the tragic realities of intergenerational drug abuse by implementing parenting skill workshops at or through the treatment setting.*[214]

More than fifteen years later, that vision remains unfulfilled, so it will be revisited in this article.

On a final introductory note, it is difficult to envision an article on the integration of medications within a recovery management paradigm without considering Buprenorphine/Suboxone/Subutex and other medications currently available (on and off label) and those in the pipeline of medication research on the treatment of opioid addiction. New medications for the treatment of heroin and other opioid addictions hold considerable promise, but that future potential does not alter the fact

---

211. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance: II. Recovery and methadone.

212. Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration.

213. Center for Substance Abuse Treatment. (1993). *State methadone treatment guidelines. Treatment Improvement Protocol (TIP) Series 1.* Rockville, MD: U.S. Department of Health and Human Services.

214. Center for Substance Abuse Treatment. (1993). *State methadone treatment guidelines. Treatment Improvement Protocol (TIP) Series 1.* Rockville, MD: U.S. Department of Health and Human Services.

that most patients in opioid treatment programs (OTPs) currently are treated with methadone.[215] No other pharmacotherapeutic agent prescribed in the treatment of heroin addiction has demonstrated such consistently high efficacy, been more widely replicated and regulated, and yet been so linked to stigma and controversy.[216] Therefore, our focus in this monograph is on methadone, and on the approach to treatment we refer to as recovery-oriented methadone maintenance (ROMM).

THE MANAGEMENT OF CHRONIC DISEASE

Either addiction is a disease or it isn't.[217]

Simply put, diseases of the human body are defined by the presence of an organ defect and predictable signs and symptoms of that defect.[218] Methadone maintenance is based on the understanding that chronic heroin addiction is a metabolic brain disease whose core symptoms include drug tolerance, withdrawal, persistent craving, and continued drug-seeking in spite of adverse consequences and failed personal resolutions to cease drug use.[219] Addiction to heroin or other short-acting exogenous opioids shares many characteristics with other primary chronic illnesses. These illnesses:

- are influenced by genetic as well as personal, family, and environmental risk factors;
- are linked to behaviors that begin as voluntary choices but evolve into compulsive behaviors fueled by neurobiological changes in the brain;
- are marked by sudden or gradual onset and a variable though often prolonged course;
- are accompanied by risk of profound pathophysiology, disability, and premature death; and
- have effective treatments, self-management protocols, peer support frameworks, and remission rates similar to those of other chronic illnesses, but no known cures.[220]

Opioid addiction has been defined as a chronic, progressive illness for more than a century, but the treatment of this disorder, like the treatment of other addictions, has been conducted primarily within an acute care (AC) model of service delivery. The AC model is marked by five distinguishing characteristics. First, care is provided within self-encapsulated, crisis-oriented episodes of care, each of which is marked by screening, admission, intake assessment, a short series of treatment procedures, discharge (with, at best, short-term follow-up), and termination of the service relationship. Second, a professional expert directs and dominates the service delivery decision-making

215. Kresina, T.F., Litwin, A., Marion, I., Lubran, R., & Clark, H.W. (2009). United States government oversight and regulation of medication assisted treatment for the treatment of opioid dependence. *Journal of Drug Policy Analysis*, *2*(1), Article 2.

216. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

217. Methadone patient email to authors, 2010

218. McCauley, K. (2009). *Pleasure unwoven: A personal journey about addiction*. Salt Lake City, UT: The Institute for the Study of Addiction.

219. Dole, V. P., & Nyswander, M. E. (1967). Heroin addiction—A metabolic disease. *Archives of Internal Medicine*, *120*, 19-24.

220. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

process. Third, services transpire over a short (and historically ever-shorter) period of time. Fourth, the individual/family/community is given the impression at discharge ("graduation") that long-term addiction recovery is now self-sustainable without further professional assistance. Fifth, post-treatment relapse and re-admissions are viewed as the failure (non-compliance) of the patient rather than a failure of service design or execution.[221]

Considerable effort is underway in primary medicine to develop models of chronic disease management,[222] and there are growing calls to shift the acute care model of addiction treatment to a model of sustained recovery support analogous to the medical management of other chronic diseases.[223] Efforts are underway at federal, state, and local levels to define and implement models of sustained *recovery management* (RM) and to nest these approaches within larger *recovery-oriented systems of care* (ROSC).[224]

RM of chronic opioid addiction is based on the following four assumptions:

- Severe and chronic opioid addiction is a brain disease characterized by neurobiological defects that are not corrected through acute detoxification.
- Exceptionally high rates of drug seeking and re-addiction following detoxification and cessation of treatment are manifestations of these neurobiological defects.
- Acute episodes of detoxification and biopsychosocial stabilization do not constitute sustainable recovery from opioid dependence and are more likely to constitute predictable milestones within a prolonged addiction career.
- Principles and practices that characterize the effective management of other chronic primary diseases can be adapted to effectively manage and improve long-term recovery outcomes in the treatment of chronic opioid (primarily heroin) addiction.

METHADONE MAINTENANCE AND RECOVERY MANAGEMENT

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—what we here refer to as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery support resources). The primary emphasis in this article will be on defining the core clinical and

221. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

222. Bodenheimer, T., Wagner, E.H., & Grumbach, K. (2002). Improving primary care for patients with chronic illness. *Journal of the American Medical Association*, *288*(14), 1775-1779. Wagner, E.H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*, *1*, 2-4. Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence to practice into action. *Health Affairs*, *20*, 64-78.

223. Dennis, M.L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55. Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use disorders: Quality chasm series*. Washington, DC: National Academy Press. McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. White, W., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-130. White, W., & McLellan, A.T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.

224. Halvorson, A., & Whitter, M. (2009). *Approaches to recovery-oriented systems of care at the state and local levels: Three case studies* (HHS Publication No. (SMA) 09-4438). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. White, W. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care* (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago: Great Lakes Addiction Technology Transfer Center. White, W. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

recovery support practices that would distinguish a recovery management approach to the treatment of opioid addiction: the who, what, when, where, and "how long" of MM treatment.

Eight arenas of service practice distinguish RM from AC models of addiction treatment: 1) attraction, access, and early engagement; 2) assessment and service planning; 3) service team composition; 4) the service relationship; 5) service quality and duration; 6) the locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term post-treatment recovery check-ups, stage-appropriate recovery support, and, when needed, early re-intervention.[225] The current status of each of these areas related to methadone maintenance will be evaluated using available scientific studies and national treatment systems performance data. The authors will also explore potential changes in service design that would increase the focus of MM on long-term recovery outcomes.

As we explore changes in clinical practices in MM, it is important to remain cognizant of the growing heterogeneity of MM patients. Today's aging MM patients, a new generation of prescription opioid addicts, and the young polyaddicted heroin/cocaine addicts steeped in a street culture of ruthlessness, risk-taking, and violence[226] all present needs much different from those of the mid-twentieth-century "cool cats" and "righteous dope fiends" whose heroin use was nested within a lifestyle of carefully crafted slickness and street sophistication.[227] Also of note is the wide variability of MM provider organizations. For example, few studies are available that illuminate potential differences between public and private MM programs, in spite of the growing privatization of MM in the United States over the past two decades.[228]

ATTRACTION, ACCESS, AND EARLY ENGAGEMENT/RETENTION

Interventions at early stages in the development of chronic diseases improve long-term health outcomes. Such early intervention is crucial in addressing conditions such as heroin addiction that often become more severe, more complex, and more intractable over time. The keys to early intervention are public knowledge about the disorder; treatments that are perceived to be effective, accessible, and affordable by those affected; systems of intervention that encourage early treatment and resolve obstacles to participation; and mechanisms that enhance service engagement and reduce early service attrition. Early intervention can be framed conceptually as including three distinct processes: 1) attracting those currently in need of treatment, 2) facilitating rapid access to services, and 3) enhancing therapeutic alliance and resolving intrapersonal, program, and environmental obstacles to continued participation.

---

225. White, W. (2008c). *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.

226. Anderson, T.L., & Levy, J.A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction*, *98*, 761-770.

227. Finestone, H. (1957). Cats, kicks and color. *Social Problems*, *5*, 3-13. Preble, E., & Casey, J. (1969). Taking care of business: The heroin user's life on the street. *International Journal of the Addictions, 4*(1), 1-24. Sutter, A.G. (1966). The world of the righteous dope fiend. *Issues in Criminology*, *2*(2), 177-222.

228. Of patients in methadone treatment in the United States on March 31, 2005, 47% were enrolled in private for-profit organizations; on March 31, 2008, that percentage had risen to 49%. Britton, B.M. (1994). The privatization of methadone maintenance: Changes in risk behavior associated with cost related detoxification. *Addiction Research & Theory*, *2*(2), 171-181. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006). *The DASIS Report: Facilities operating opioid treatment programs: 2005. Issue 36*. Retrieved January 13, 2010 from http://www.oas.samhsa.gov/2K6/OTP/OTP.cfm. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008*.

Attraction

Methadone maintenance treatment attracts voluntarily participation by more people addicted to heroin and other short-acting opioids than any other addiction treatment modality,[229] but most people addicted to heroin and other opioids are not currently enrolled in addiction treatment. There are an estimated 750,000 to 1,000,000 opioid (primarily heroin) addicts in the United States,[230] but only 337,342 persons with a primary drug choice of heroin (246,835; 13.6% of all admissions) or other opioids (90,489; 5% of all admissions) were admitted to addiction treatment in the United States in 2007.[231] Of these admissions, only 29% received methadone or buprenorphine as a planned part of their treatment.[232] A 2008 survey identified 1,132 certified OTPs in the United States (8% of the 13,688 treatment facilities in the U.S.).[233] A March 31, 2008 survey of OTPs in the United States found that 268,071 patients were being treated with methadone and 4,280 were being treated with buprenorphine.[234]

Methadone maintenance is considered the most effective treatment for chronic heroin dependence,[235] but the percentage of heroin-dependent people seeking treatment who receive methadone pharmacotherapy declined precipitously between 1992 and 2007 (from 42% to 22%).[236] The systems in which heroin addicts are most likely to be encountered (the health care and criminal justice systems) refer only a small fraction (5.5%) of those currently enrolled in MM. Most patients entering methadone treatment get to MM by self/family referral (72.8%). Other addiction treatment providers make up only 9.6% of MM referrals, with other referral sources including health care providers (4.2%) and other community referrals (6.1%).[237] Heroin users still linked to conventional society through living with family or an intimate partner are more likely to seek treatment than those living in isolation from such connections.[238] Breaking such isolation may require special outreach services to elicit treatment seeking.

The most common pattern of treatment for injection drug users consists of multiple episodes of detoxification—the least effective of all treatments for opioid addiction.[239] A recent Massachusetts study of first treatment entry for injection drug users revealed that 66% sought detoxification, 15% outpatient counseling, 14% methadone maintenance, and 5% residential treatment.[240] The same study found that, throughout the six-year span of the study, 30% of injection drug users experienced multiple episodes of detoxification but did not participate in any additional treatment.[241] What is of most concern is the finding that those who seek heroin detoxification only and eschew further treatment have the fewest resources to support a process of long-term recovery.[242]

---

229. Kreek, M. J. (2000). Methadone-related agonist therapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of the New York Academy of Science, 909*, 186-216.

230. Lloyd, J. (2003). *Heroin*. Washington, D.C.: Office of National Drug Control Policy.

231. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *Highlights for 2007 Treatment Episode Data Set (TEDS), Table 2a.* Retrieved November 23, 2009 from http://www.oas.samhsa.gov/TEDS2k7highlights/TEDShigh2k7Tb2a.htm.

232. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *Highlights for 2007 Treatment Episode Data Set (TEDS), Table 4.*

233. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008.*

234. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008.*

235. NIH. (1998). Effective medical treatment of opiate addiction: National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. *Journal of the American Medical Association, 280*(22), 1936-1943. Retrieved from http://odp.od.nih.gov/consensus/cons/108/108_statement.htm.

236. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Treatment Episode Data Set—Admissions (TEDS-A)—Concatenated, 1992 to Present [Computer file]. ICPSR25221-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2009-09-21. doi:10.3886/ICPSR25221.

237. United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. Treatment Episode Data Set—Admissions (TEDS-A)—Concatenated, 1992 to Present [Computer file]. ICPSR25221-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2009-09-21. doi:10.3886/ICPSR25221.

238. Lloyd, J.J., Ricketts, E.P., Strathdee, S.A., Cornelius, L J., Bishai, D., Huettner, S., Latkin, C. (2005). Social contextual factors associated with entry into opiate agonist treatment among injection drug users. *The American Journal of Drug and Alcohol Abuse, 31*(4), 555-570.

239. Simpson, D.D., & Sells, B.S. (1990). *Opioid addiction and treatment: A 12-year follow-up*. Malabar, FL: Krieger Publishing.

240. Lundgren, L.M., Sullivan, L., & Amodeo, M. (2006). How do repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment, 30*, 121-128.

Popular and professional conceptions of methadone as a "legal substitute for heroin," street myths about methadone (e.g., "it rots your bones"), and the view that MM is a "last resort" inhibit timely treatment seeking by those who could benefit from MM.[243] Such views about methadone are particularly magnified within minority communities.[244]

The myths, misconceptions, and stigma surrounding heroin addiction, methadone, and methadone treatment; the public visibility of the worst methadone clinics and the least stabilized MM patients; and the virtual invisibility of the best OTP clinics and the most successful MM patients create a climate in which people enter MM mostly under conditions of extreme desperation and only in the late stages of their addiction careers. The average duration of heroin use prior to first admission to treatment ranges from 6-10 years[245] to 14.5 years,[246] and an average span of 22 years' heroin use precedes the onset of long-term recovery from heroin addiction (with recovery defined in this study as 5 years' continuous heroin abstinence).[247]

Future efforts to attract people who are heroin dependent to enter MM include national and local professional education campaigns, targeted education of injection drug users, increasing the recovery orientation of syringe exchange programs, community intervention programs aimed at early problem identification and assertive linkage to MM or alternative treatments (via physicians, hospitals, health clinics, police, etc.), community education campaigns about opioid addiction and the effectiveness of MM as a medical treatment of heroin addiction, and street outreach programs conducted by people who offer themselves as "living proof" of the reality of long-term medication-assisted recovery.

Recovery catalysts (outreach workers) trolling the natural environments of prospective patients can reach, motivate, and engage individuals who resist entering MM due to their own ambivalence about giving up heroin and the associated lifestyle.[248] Such workers challenge the myths about methadone and correct the view that MM is not accessible, effective, or affordable. They also avoid using ineffective pleas and threats such as those that warn of continued pain and the threat of death. People addicted to heroin and other opioids all too often are already drowning in pain, disregard death as a potential consequence of heroin use (e.g., by avoiding overdose protection measures), and even view the possibility of death as a seductive source of escape.[249] Outreach in ROMM is often based on the recognition that sparking the recovery initiation process is more about hope (seeing the top) than about a heightened experience of pain (hitting bottom). And sometimes it is as simple as get-

241. Lundgren, L.M., Sullivan, L., & Amodeo, M. (2006). How do repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment*, *30*, 121-128.

242. Lundgren, L.M., Schilling, R., Ferguson, F., Davis, K., & Amodeo, M. (2003). Examining drug treatment program entry of injection drug users: Human capital and institutional disaffiliation. *Evaluation and Program Planning*, *26*, 123-132.

243. Appel, P.W., Ellison, A.E., Jansky, H.K., & Oldak, R. (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system stakeholders. *American Journal of Drug and Alcohol Abuse*, *30*(1), 129-153. Hunt, D. E., Litpon, D. S., Goldsmith, D. S., Strug, D. L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner city methadone clinic. *Journal of Urban Health*, *79*, 571-578.

244. Amodeo, M., Chassler, D., Ferguson, F., Fitzgerald, T., & Lundgren, L. (2004). Use of mental health and substance abuse treatment services by female injection drug users. *American Journal of Drug and Alcohol Abuse*, *30*, 101-120. Lundgren, L.M., Amodeo, M., Ferguson, F., & Davis, K. (2001). Racial and ethnic differences in drug treatment entry of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment*, *21*, 145-153. Zaller, N.D., Bazazi, A.R., Velazquez, L., & Rich, J.D. (2009). Attitudes toward methadone maintenance among out-of-treatment minority injection drug users: Implications for health disparities. *International Journal of Environmental Research on Public Health*, *6*(2), 787-797.

245. Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(3), 1-16.

246. Lundgren, L.M., Schilling, R., Ferguson, F., Davis, K., & Amodeo, M. (2003). Examining drug treatment program entry of injection drug users: Human capital and institutional disaffiliation. *Evaluation and Program Planning*, *26*, 123-132.

247. Hser, Y. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51-60.

248. Booth, R.E., Corsi, K.F., & Mikulich, S. K. (2003). Improving entry to methadone maintenance among out-of-treatment injection drug users. *Journal of Substance Abuse Treatment*, *24*, 305-311. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

ting a clear message to those in need of services. Imagine a sign visible in every emergency room and ambulatory care center reading, "Dependence on narcotics is a medical problem that can be treated effectively. Ask our staff about taking the first step toward recovery."[250]

A study by Amodeo and colleagues[251] offers another potential clue for outreach within ROMM. Their study found that female injection drug users who had previously received mental health services were 66% more likely to enter treatment beyond detoxification than female injection drug users who had not received such services. Outreach aimed at linking and providing mental health services to injection drug users may provide a novel window of opportunity for subsequent engagement in MM and other addiction treatment modalities.

Patient attraction to methadone maintenance would also be enhanced if all opioid-addicted patients seeking treatment were afforded objective choices about their treatment options regardless of the settings in which they were screened and evaluated. For example, patients who were seeking buprenorphine treatment but discover they cannot afford this treatment should be provided treatment options that include MM as well as other treatment options that are more affordable. The clarification of patient expectations of treatment and a presentation of treatment choices through a more education-oriented consent-to-treatment process would enhance each patient's capacity for informed decision-making. The goals would be to correct false expectations, enhance the best match between patient and treatment approach/setting, and ensure that each patient has sufficient information and understanding to appreciate the benefits and risks of MM and other addiction treatment modalities. All addiction treatment programs should be required to provide regular opportunities for patients and family members to evaluate the treatments they are receiving and should make the results of these evaluations available to prospective patients/families and referral sources.

A final issue related to patient attraction to MM involves the attractiveness, accessibility, perceived safety, and overall community reputation of the OTP.

Access

Rapid access to addiction treatment is particularly critical for injection drug users due to their ambivalence about treatment and about ceasing heroin use, their low frustration tolerance, their likelihood of continued drug use, and the high risk of harm to self and others via overdose death, HIV transmission, and criminal behavior.[252] Reports from MM counselors include vivid accounts of people dying while on waiting lists to enter treatment.[253] Between 25-50% of persons on waiting

249. Miller, P. (2009). Safe using messages may not be enough to promote behavior change amongst injecting drug users who are ambivalent or indifferent toward death. *Harm Reduction Journal*, *6*:18.

250. Dr. Robert Newman, Personal Communication, July 2, 2010.

251. Amodeo, M., Chassler, D., Ferguson, F., Fitzgerald, T., & Lundgren, L. (2004). Use of mental health and substance abuse treatment services by female injection drug users. *American Journal of Drug and Alcohol Abuse*, *30*, 101-120.

252. Chun, J., Guydish, J.R., Silber, E., & Gleghorn, A. (2008). Drug treatment outcomes for persons on waiting lists. *The American Journal of Drug and Alcohol Abuse, 34*, 526-533. Clausen, T., Ancherson, K., & Waal, H. (2008). Morality prior to, during and after opioid maintenance treatment (OMT): A national prospective cross-registry study. *Drug and Alcohol Dependence, 94*(1-3), 151-157. Gryczynski, J., Schwartz, R., O'Grady, K., & Jaffe, J. (2009). Treatment entry among individuals on a waiting list for methadone maintenance. *The American Journal of Drug and Alcohol Abuse*, *35*, 290-294.

253. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts*. Tucson, AZ: Wheatmark.

lists fail to enter addiction treatment,[254] with as many as 40% of persons dropping out of the waiting list within the first two weeks.[255] MM treatment access can be limited—even for the most highly motivated patient—by lack of geographical proximity, inadequate treatment capacity/waiting lists for treatment admission, restrictive admission criteria, the demand for daily attendance, limited timeframes within which individuals can receive medication or pick up take-home medication, shaming rituals (e.g., standing in line on public streets, frontally-observed urination for drug testing), lack of insurance and prohibitive service fees, homelessness, child care, and language and cultural barriers.[256]

Potential patients have also experienced lost access to MM through closure of public treatment programs or their inability to pay for public or private treatment. Studies of such patients who have lost access to MM have documented adverse personal and community consequences.[257] It is critical that each OTP have an emergency plan that anticipates how each patient will be medicated in the event of a brief, prolonged, or permanent disruption in services at the clinic—a current requirement of the OTP accreditation process.

Future efforts to increase access to MM treatment include increased public and private funding to expand MM treatment capacity, distribution of coupons for free treatment, regulatory reform to minimize obstacles to treatment access, expedited admission (e.g., interim maintenance-methadone without counseling), and moving stabilized patients to medical maintenance (methadone provided by a primary care physician).[258]

For patients willing to enter MM only on a time-limited basis,[259] MM programs could admit patients under such conditions; provide patient education about the benefits of longer periods of maintenance; and, for those patients choosing to taper quickly, provide assertive post-treatment recovery check-ups to offer support, monitor recovery stability, and provide rapid re-engagement in treatment as needed (with or without methadone pharmacotherapy). Potential patients resistant to MM could be offered other treatment options, including alternative pharmacotherapies (e.g., buprenorphine). The goal of these efforts would be to shorten addiction careers and improve recovery outcomes by intervening in the progression of addiction at earlier stages of problem severity and complexity at a time when patients still have personal/family recovery capital that can be mobilized to enhance recovery initiation and recovery maintenance.

---

254. Donovan, D.M, Rosengren, D.B., Downey, L., Cox, G.B., & Sloan, K.L. (2001). Attrition prevention with individuals awaiting publicly funded drug treatment. *Addiction, 96*(8), 1149-1160. Stark, M.J., Campbell, B.K., & Brinkerhoff, C.V. (1990). "Hello, may I help you?" A study of attrition prevention at the time of the first phone contact with substance-abusing clients. *American Journal on Drug and Alcohol Abuse*, *16*(1-2), 67-76.

255. Kaplan, E.H., & Johri, M. (2000). Treatment on demand: An operational model. *Health Care Management Science, 3*, 171-183.

256. Peterson, J.A., Schwartz, R.P., Mitchell, S.G., Reisinger, H.S., Kelly, S. M., O'Grady, K.E., Agar, M.H. (2010). Why don't out-of-treatment individuals enter methadone treatment programmes? *International Journal of Drug Policy, 21*, 26-42. Zaller, N.D., Bazazi, A.R., Velazquez, L., & Rich, J.D. (2009). Attitudes toward methadone maintenance among out-of-treatment minority injection drug users: Implications for health disparities. *International Journal of Environmental Research on Public Health*, *6*(2), 787-797.

257. Anglin, M.D., Speckart, G.R., Booth, M.W., & Tyan, T.M. (1989). Consequences and costs of shutting off methadone. *Addictive Behaviors*, *14*(3), 307-326. Rosenbaum, M., Murphy, S., & Beck, J. (1987). Money for methadone: Preliminary findings from a study of Almeda County's new methadone policy. *Journal of Psychoactive Drugs*, *19*, 13-19.

258. Appel, P.W., Ellison, A.E., Jansky, H.K., & Oldak, R. (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system stakeholders. *American Journal of Drug and Alcohol Abuse*, *30*(1), 129-153. Booth, R.E., Corsi, K.F., & Mikulich-Gilbertson, S.K. (2004). Factors associated with methadone maintenance retention among street-recruited injection drug users. *Drug and Alcohol Dependence, 74*(2), 177-185. Fiellin, D.A., O'Connor, P.G., Chawarski, M., Pakes, J.P., Pantalon, M.V., & Schottenfeld, R.S. (2001). Methadone maintenance in primary care. *Journal of the American Medical Association*, *286*(14), 1724-1731. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments: Blending conference session. *Journal of Substance Abuse Treatment, 23*(2), 93-105. Kwiatkowski, C.F., Booth, R.E., & Lloyd, L.V. (2000). The effects of offering free treatment to street-recruited opioid injectors. *Addiction, 95*(5), 697-704. Maddux, F.F., Prihoda, T.J., & Desmond, D.P. (1994). Treatment fees and retention on methadone maintenance. *Journal of Drug Issues*, *24*, 429-443. Maddux, J.F., Desmond, D.P., & Esquivel, M. (1995). Rapid admission and retention on methadone. *American Journal of Drug and Alcohol Abuse*, *21*(4), 533-547. Schwartz, R. P., Jaffe, J.H., O'Grady, K.E., Das, B., Highfield, D.A., & Wilson, M. E. (2009). Scaling-up interim methadone maintenance: Treatment for 1,000 heroin-addicted individuals. *Journal of Substance Abuse Treatment*, *37*, 362-367. Senay, E.C., Barthwell, A.G., Marks, R., Boros, P., Gillman, D., & White, G. (1993). Medical maintenance: A pilot study. *Journal of Addictive Diseases*, *12*, 59-76.

259. Peterson, J.A., Schwartz, R.P., Mitchell, S.G., Reisinger, H.S., Kelly, S.M., O'Grady, K.E., Agar, M.H. (2010). Why don't out-of-treatment individuals enter methadone treatment programmes? *International Journal of Drug Policy, 21*, 26-42.

There is also an issue of MM patients' access to other needed addiction treatment modalities. Historically, MM patients have been refused admission to abstinence-based addiction treatment and recovery support services, e.g., refused admission to alcohol detoxification, residential treatment, and sober living facilities.[260] Efforts to involve MM patients in these services have shown positive results and should be expanded via professional education and the establishment of formal linkages between OTPs and other addiction treatment programs.[261] OTPs can improve this situation by educating other treatment providers about the benefits of concurrent treatment, advocating on behalf of their patients (e.g., for state regulations that prohibit such discriminatory exclusion), and encouraging patients who have been denied access to treatment to seek legal redress. Some state addiction treatment authorities (e.g., Maine) explicitly prohibit (as a condition of licensing or funding) programs from refusing admission of patients who are also enrolled in medication-assisted treatment.

Early Engagement and Retention

Another distinctive feature of recovery management approaches is their emphasis on enhancing early patient engagement in the treatment process. This is related to two issues we will discuss later—therapeutic alliance and duration of service involvement—and the critical role each plays in influencing long-term recovery outcomes.

Recent reviews[262] of patient retention studies lead to six critical conclusions:

- Sustained treatment retention is critical to long-term recovery outcomes: "Addiction is a chronic relapsing disorder and short-term treatment is not likely to have any lasting impact."[263]
- MM programs retain opioid-addicted patients at higher rates than all other treatment modalities, but retention remains a significant problem in MM treatment.[264]
- Though MM was originally conceptualized as a prolonged if not lifelong treatment, the majority of newly admitted MM patients drop out within the first year.
- Retention and dropout rates vary widely from program to program.
- Retention and dropout are more related to in-treatment program factors than pre-treatment patient factors.[265]

---

260. Hettema, J.E., & Sorensen, J.L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*, *7,* 468-474. NIAAA. (1988, updated 2000). Methadone maintenance and patients in alcoholism treatment. *Alcohol Alert No. 1* (August). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

261. De Leon, G., Stains, G.L., Perlis, T.E., Sacks, S., McKendrick, K., Hilton, R., & Brady, R. (1995). Therapeutic community methods in methadone maintenance (Passages): An open clinical trial. *Drug and Alcohol Dependence, 37*, 45-57. Kipnis, S.S., Herron, A., Perez, J., & Joseph, H. (2001). Integrating the methadone patent in the traditional addiction inpatient rehabilitation program,--problems and solutions. *The Mount Sinai Journal of Medicine*, *68*(1), 28-32. Lewis, D.C. (1999). Access to narcotic addiction treatment and medical care: Prospects for the expansion of methadone maintenance treatment. *Journal of Addictive Diseases*, *18*(2), 5-21. Sorensen, J.L., Andrews, S., Delucchi, K.L., Greenberg, B., Guydish, J., Masson, C.L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. Drug and Alcohol Dependence, *100*(1–2), 100–106.

262. Reisinger, H.S., Schwartz, R.P., Mitchell, S.G., Peterson, J.A., Kelly, S.M., O'Grady, K.E., Agar, M.H. (2009). Premature discharge from methadone treatment: Patient perspectives. *Journal of Psychoactive Drugs*, *41*(3), 285-296.

263. O'Brien, C. P. (2005). Opiate detoxification: What are the goals? *Addiction*, *100*, 1035.

264. Mattick, R.P., Breen, C., Kimber, J. & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database Syst Rev(*2), CD002209.

265. Magura, S., Nwakeze, P., & Demsky, S. (1998). Pre- and in-treatment predictors of retention in methadone treatment using survival analysis. *Addiction*, *93*(1), 51-60.

- Early dropout is related to four factors: 1) program-related factors (e.g., arbitrary and unequally enforced rules, conflict with one's counselor, discharge for non-payment of fees, schedule conflicts that interfere with daily pickups), 2) dissatisfaction with methadone (e.g., fear of prolonged dependence on medication and the clinic), 3) life events/logistics (e.g., stressful events or other obstacles that interfere with treatment participation), and 4) incarceration due to past legal problems or new minor criminal charges (e.g., loitering).

As we will review shortly, the optimum effects of MM in terms of full biopsychosocial recovery require a sustained period of treatment participation. Failure to establish a strong therapeutic alliance with each patient and early disengagement from treatment are key indicators that these optimum effects will not be achieved.[266] Of those admitted to MM, 24% drop out in the first 60 days,[267] with new patients dropping out at higher rates than returning patients—31% versus 20% in the first 90 days of treatment.[268] Studies have shown that the same factors that inhibit access also contribute to premature disengagement from MM, factors that include misconceptions and negative attitudes about methadone.[269] A critical finding worth restating is that patient retention in treatment is predicted more by program characteristics, including degree of therapeutic engagement, than by the patient's demographic or clinical characteristics.[270]

Among critical program factors that influence retention are medication dose, which we will discuss shortly, and each patient's belief that he or she is being treated fairly and with dignity and that his or her preferences are being respected. The "patient-centered approach" advocated by the Institute of Medicine[271] is the ideal for OTPs. Because of the amount of time the counselor spends with the patient compared to the time spent by other staff, the counselor plays a pivotal role in this process of patient engagement. Due-process assurances and the right of redress (e.g., grievance processes) are critical to resolving early problems in this engagement process.

Promising practices related to early engagement and retention include interim MM, rapid admission, same-day dosing, expanded clinic hours, individualized methadone doses with no dose floors or ceilings, formal patient/family orientation sessions, increased numbers of patient options, patient participation in clinical decision-making, peer guides for new patients, telephone prompts following missed appointments, patient education related to safety and pharmacology (e.g., how methadone works to overcome withdrawal, suppress cravings, provide feeling of "normalcy," create a blockade effect), provision of specialized services for co-occurring mental

266. Broome, K.M., Simpson, D.D., & Joe, G.W. (1999). Patient and program attributes related to treatment process indicators in DATOS. *Drug and Alcohol Dependence, 57*, 127-135. Meier, P. S., Barrowclough, C., & Donmall, M.C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, *100*, 304-316.

267. Simpson, D.D., & Joe, G.W. (1993). Motivation as a predictor of early dropout from drug abuse treatment. *Psychotherapy: Theory, Research and Practice*, *30*(2), 357-368.

268. Deren, S., Goldstein, M.F., Des Jarlais, D.C., Richman, B.L., Kang, S-J., & Flom, P.L. (2001). Drug use, HIV-related risk behaviors and dropout status of new admissions and re-admissions to methadone treatment. *Journal of Substance Abuse Treatment*, *20*(2), 185-189.

269. Zaller, N.D., Bazazi, A.R., Velazquez, L., & Rich, J.D. (2009). Attitudes toward methadone maintenance among out-of-treatment minority injection drug users: Implications for health disparities. *International Journal of Environmental Research on Public Health*, *6*(2), 787-797.

270. Lowinson, J.H. (1977). Commonly asked clinical questions about methadone maintenance. *The International Journal of the Addictions*, *12*(7), 821-835. Meier, P.S., Barrowclough, C., & Donmall, M.C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction*, *100*, 304-316.

271. Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use disorders: Quality chasm series*. Washington, DC: National Academy Press.

illnesses, use of patient advocates to resolve conflicts with staff, and completion of patient satisfaction surveys/interviews.[272] Another possible engagement strategy would be to reach out via intense peer-based educational interventions with patients who recycle through short heroin detoxification episodes without ever achieving an optimal therapeutic dose for maintenance pharmacotherapy.

Key recovery-focused systems performance measures related to attraction, access, and early retention include community-level measures of social and professional stigma related to MM, attitudes toward MM among persons who are in need of but not currently in treatment, referral source patterns (e.g., increases in self-referrals and referrals from systems traditionally hostile to MM), length of opioid use prior to first admission, percentage of admissions without prior addiction treatment, percentage of admissions without prior MM treatment, average time lag between help seeking and treatment admission, percentage of patients admitted from waiting lists, and early treatment retention.

ASSESSMENT AND SERVICE PLANNING

Assessment processes for patients with chronic diseases differ from assessment of acute disorders due to the following principle: chronic diseases beget other acute and chronic disorders that collectively exert sustained and profound strain on the patient and family. Assessment of chronic disorders is therefore global in scope, family-inclusive, and continual.

Assessment and service planning procedures within MM programs historically have paralleled those used in acute-care models of addiction treatment. A team of professionals conducts an initial screening and assessment, verifies and diagnoses opioid addiction, admits the patient, identifies primary and collateral problems, generates a professional treatment plan that delineates how these problems will be addressed, and maintains progress notes related to service activities aimed at the identified problems. Efforts to increase the recovery orientation of these processes include:

- shifting from categorical to global assessment instruments and interview protocols;
- conceptualizing the family (as defined by the patient) as the unit of service rather than the individual patient;

272. Bao, Y-P., Liu, Z-M., Epstein, D., Du, C., Shi, J., & Lu, L. (2009). A meta-analysis of retention in methadone maintenance by dose and dosing strategy. *The American Journal of Drug and Alcohol Abuse, 35,* 28-33. Deck, D., & Carlson, M. J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60. Maddux, J.F., Desmond, D. P., & Esquivel, M. (1995). Rapid admission and retention on methadone. *American Journal of Drug and Alcohol Abuse*, *21*(4), 533-547. Reisinger, H.S., Schwartz, R.P., Mitchell, S.G., Peterson, J.A., Kelly, S.M., O'Grady, K.E., Agar, M.H. (2009). Premature discharge from methadone treatment: Patient perspectives. *Journal of Psychoactive Drugs*, *41*(3), 285-296. Schwartz, R.P., Jaffe, J.H., O'Grady, K.E., Das, B., Highfield, D.A., & Wilson, M. E. (2009). Scaling-up interim methadone maintenance: Treatment for 1,000 heroin-addicted individuals. *Journal of Substance Abuse Treatment*, *37,* 362-367. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner city methadone clinic. *Journal of Urban Health*, *79*, 571-578.

- using a strengths-based assessment process to identify personal, family, and community/cultural assets that can be mobilized to support recovery initiation and maintenance;
- viewing assessment as a continual versus single-point-in-time intake process (based on the understanding that service needs change across the developmental stages of recovery); and
- making the transition from professionally directed treatment plans to patient-directed recovery plans.[273]

Traditional assessment processes (and level-of-care and modality-placement decisions) in addiction treatment have relied primarily on an assessment of addiction severity (its acuity and chronicity) and complexity (co-occurring problems and obstacles to recovery). Recovery management approaches to MM balance this emphasis on pathology assessment with an assessment of recovery capital in decisions related to placement, readiness for take-home privileges, and responses to a patient's interests or preferences related to tapering. For example, a patient presenting with high problem severity, but exceptionally high recovery capital may require lower treatment intensity and shorter duration than the patient presenting with lower problem severity but little or no recovery capital.[274] Assessing recovery capital and delivering services aimed at mobilizing and increasing internal and external recovery capital are essential strategies within recovery management approaches to the treatment of opioid dependence.

Neither the assessment nor counseling processes within MM programs have historically focused on needs of the children of MM patients, parenting concerns of MM patients, or the needs of the family as a whole.[275] We envision a future in which MM programs will offer a wide menu of child-, parent-, and family-focused recovery support services (See later discussion).

COMPOSITION OF THE SERVICE TEAM

Treatment of chronic diseases, in contrast to the treatment of acute disease or trauma, involves a broader multidisciplinary team and a greater emphasis on peer support for long-term recovery management. The typical staffing pattern of MM programs in the United States is made up of medical staff (physicians, physician's assistants, nurses, and nurse practitioners), counseling staff, and ancillary professionals (pharmacists, psychologists, and social workers).[276] We anticipate significant changes in the composition and duties of staff of MM programs that pursue greater recovery orientation, including expanded:

---

273. Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment, 15*(1), 37-42. White, W. (2008c). *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.

274. White, W., & Cloud, W. (2008). Recovery capital: A primer for addiction professionals. *Counselor, 9*(5), 22-27.

275. Lundgren, L.M., Schilling, R.F., & Peloquin, S.A.D. (2005). Evidence-based drug treatment practice and the child welfare system: The example of methadone. *Social Work*, *50*(1), 53-63.

276. Calsyn, D., Saxon, A.J., Blaes, P., & Lee-Meyer, S. (1990). Staffing patterns of American methadone maintenance programs. *Journal of Substance Abuse Treatment*, *7*, 255-259.

- roles of addiction medicine specialists in patient/family/community education;
- involvement of primary care physicians in MM treatment, including co-location of MM clinics and primary health care clinics (potential conduits for opening office-based treatment sites);
- use of case managers, freeing counselors to do scheduled recovery-focused counseling;
- involvement of therapists trained in clinical work with families and children;
- use of current and former patients in medication-assisted recovery as staff and volunteers within the MM milieu, e.g., as patient educators, recovery coaches, and advocates; and
- use of indigenous healers drawn from diverse cultural communities, e.g., leaders of faith-based recovery ministries.

These staffing changes are congruent with the RM focus on recovery as a process of enhanced global health and positive community re-integration and its emphasis on the potential contributions of peer-based recovery support services (P-BRSS) in long-term recovery from opioid addiction.

Medical staff members play a central role in service delivery during a patient's involvement in MM, but physician roles in MM focus primarily on conducting physical examinations, setting dosing levels, and performing administrative activities. Similarly, nursing time in OTPs is consumed primarily in dispensing medication for a high volume of patients. Most OTP physicians and nurses are not, or are only peripherally, involved in broader aspects of care delivery, nor are they involved in the sustained monitoring and support of patients following cessation of MM.[277] Some MM patients who reviewed a summary of this monograph were quite critical of the lack of physician involvement in their care.

> *I have NEVER MET the doctor whose name is on my methadone take home bottles. Never once in 15 years. There is no medicine going on in the MMT system.*[278]

One of the principles of RM is that every patient in recovery needs a sustained relationship with a primary care physician. Ideally, these physicians are involved as partners in the addiction treatment process, play a central role in the long-term management of health and wellness, and conduct ongoing post-treatment recovery check-ups.

---

277. Loth, C., Schippers, G.M., Hart, H., & van de Wijngaart, G. (2007). Enhancing the quality of nursing care in methadone substitute clinics using action research: A process evaluation. *Journal of Advanced Nursing, 57*(4), 422-431. Wechsberg, W.M., Flannery, B., Kasten, J.J., Suerken, C., Dunlap, L., Roussel, A.E., & Diesenhaus, H. (2004). Physicians practicing in methadone treatment programs: Who are they and what do they do? *Journal of Addictive Diseases, 23*(2), 15-31.

278. MM patient feedback to authors, May 2010.

We anticipate greater involvement of primary care physicians in MM treatment, experiments in co-location of MM clinics and primary health care clinics, and an increased number of experiments delivering methadone treatment through the auspices of primary care physicians. Integrating addiction medicine and primary medicine may be particularly important for older MM patients who face risks of premature death from such co-occurring conditions as nicotine dependence and diabetes.[279] The high rate of psychiatric co-morbidity of MM patients and their generally low quality of life would also suggest a potentially greater role for psychologists and social workers in MM programs.[280]

As a byproduct of the professionalization of addiction counseling, the percentage of addiction counselors with a history of personal recovery decreased from more than 70% in the late 1960s to 30% in 2009.[281] Recovery representation is even lower in the MM arena, in spite of the fact that many MM patients recommended the use of recovering counselors in surveys asking them to identify the ideal characteristics of an MM program.[282] Calsyn and colleagues'[283] study of staffing patterns in MM programs found that less than half of MM programs had any staff in recovery, and only 10% of all MM staff in the United States self-identified as being in recovery. We anticipate a number of innovative, MM-specific peer recovery support initiatives in the near future that will forever reshape the milieu of methadone maintenance in the United States.[284] We anticipate a day when current and former MM patients in stable recovery are ever-present within OTPs via their roles as service staff, members of governing boards and patient advisory councils, and through formal volunteer programs and alumni associations.

From the standpoint of long-term recovery management, peer-based recovery support services can play a critical role in outreach (pre-recovery identification and recovery priming), recovery initiation and stabilization, transition to recovery maintenance, and enhancing the quality of personal and family life in long-term recovery (with or without continued methadone pharmacotherapy). Some OTPs, such as Beth Israel Medical Center in New York City, recruited patients who had been optimally dose—stabilized for years to be trained and credentialed as addiction counselors. Other OTPs are exploring the use of non-clinical peer-based recovery support services. Of particular note is the development of a peer-based recovery support services model for patients in methadone treatment via the CSAT-funded Medication Assisted Recovery Services (MARS) project in New York City.[285]

279. Fareed, A., Casarella, J., Amar, R., Vayalapalli, S., & Drexler, K. (2009). Benefits of retention in methadone maintenance and chronic health conditions as risk factors for premature death among older heroin addicts. *Journal of Psychiatric Practice*, *15*(3), 227-234. Lofwall, M.R., Brooner, R.K., Bigelow, G.E., Kindbom, K., & Strain, E. C. (2005). Characteristics of older opioid maintenance patients. *Journal of Substance Abuse Treatment*, *28*, 265-272.

280. Carpentier, P.J., Krabbe, P.F., van Gogh, M.T., Knapen, L.J., Buitelaar, J.K., & de Jong, C.A. (2009). Psychiatric comorbidity reduces quality of life in chronic methadone maintained patients. *American Journal on Addictions*, *18*(6), 470-480.

281. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

282. Jones, S.S., Power, R., & Dale, A. (1994). The patients' charter: Drug users' views on the "ideal" methadone programme. *Addiction Research*, *1*(4), 323-334.

283. Calsyn, D., Saxon, A.J., Blaes, P., & Lee-Meyer, S. (1990). Staffing patterns of American methadone maintenance programs. *Journal of Substance Abuse Treatment*, *7*, 255-259.

284. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

285. Ginter, W. (2009). *Advocacy for medication-assisted recovery*. Retrieved November 4, 2009 from http://www.facesandvoicesofrecovery.org/publications/profiles/walter_ginter.php.

THE SERVICE RELATIONSHIP

Relationships between patients with chronic diseases and their service providers are markedly different than interactions surrounding the treatment of acute disorders. The treatment of acute disorders places the physician and care team in a position of elevated power and responsibility to "fix" the problem presented by the patient. In contrast, the patient with a chronic disease bears central responsibility for managing his or her own recovery in consultation with his or her professional care providers. Physicians and the broader care team provide ongoing adjustments in medical management (e.g., medications) and respond to acute crises, but they play equally important roles as educators, consultants, and recovery coaches. In these latter roles, they provide to each patient a rich menu of information and support services. As we shall see, the scope, depth, and duration of resources provided to patients managing other chronic diseases are far greater than those of the resources offered to current and former methadone patients.

The service relationships within chronic disease management are particularly distinctive in terms of their duration (measured in years or decades), the high degree of intimacy that develops between service providers and the patient and family, and the broader focus of the relationship—the global health and functioning of the patient and family rather than treatment of a particular health defect. One would think that service relationships within OTPs would reflect this type of relationship, given MM's foundational belief that opioid dependence is a chronic disease requiring sustained and active management.

The importance of the therapeutic alliance in the treatment of addiction is clearly evident in the early publications of the developers of MM. Dr. Marie Nyswander declared that the most important thing in the life of a drug addict is "to be understood." She called upon treatment providers to "convey an interest in every aspect of the patient's life."[286] Dr. Nyswander's capacity for such alliances with her patients was legendary, and Dr. Dole was fond of suggesting that it was impossible to rehabilitate any patient without getting to know the patient as a human being.[287]

> *I made a practice of spending two or three hours almost every day just sitting and talking with the addicts in a somewhat aimless way. I was just trying to get a sense of their way of thinking, their values, their experiences. They educated me about a world that was out of my reach, one that I had never been in and would never enter.*[288]

286. Nyswander, M. (1956). *The drug addict as a patient*. New York: Grune & Stratton.

287. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais (Eds.), *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

288. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais (Eds.), *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

Like teachers in a one-room school, we knew each patient personally.[289]

Dr. Mary Jeanne Kreek also extolled the importance of listening to patients as the most important quality of those working in MM treatment.

> *Less easily measured than blood levels of the pharmacotherapeutic agent, urine content of a drug of abuse, receptor or peptide ligand levels, or the myriad of social and psychological indices measured by well-validated instruments of psychology and psychiatry are those qualities that make any individual staff member an excellent and human care giver.*[290]

MM in its earliest years was grounded in a relationship free of contempt and in attitudes of personal respect and professional humility.[291] The climate of partnership between the original MM pioneers and their patients was so strong that critics suggested their outcomes were a product of the supportive milieu rather than of methadone. "There's something very special about the climate at Rockefeller" was proffered by such detractors as a criticism rather than a compliment.[292]

MM pioneers grieved the loss of such relationships as MM was widely diffused in the United States and beyond.

> *The most any chemical agent can do for an addict is to relieve his compulsive drive for illicit narcotics. To give him hope and self-respect requires human warmth; to become a productive citizen he needs the effective support of persons who can help him find a job and protect him from discrimination. It is in these human qualities that the [methadone maintenance] programs of the past five years have failed.*[293]

> *… to succeed in bringing disadvantaged addicts to a productive way of life, a treatment program must enable its patients to feel pride and hope and to accept responsibility. This is often not achieved in present-day [methadone maintenance] treatment programs. Without mutual respect, an adversary relationship develops between patients and staff, reinforced by arbitrary rules and the indifference of persons in authority. Patients held in contempt by the staff continue to act like addicts…* [294]

---

289. Dole, V. P. (1971). Methadone maintenance treatment for 25,000 addicts. *Journal of the American Medical Association*, *215*, 1131-1134.

290. Kreek, M.J. (1993). Epilogue—a personal restrospective and prospective viewpoint. In M.W. Parrino, *State Methadone Guidelines: Treatment Improvement Protocol (TIP) Series 1*. Rockville, MD: Center for Substance Abuse Treatment.

291. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4. Newman, R. G. (2000). Addiction and methadone. *Heroin Addiction & Related Clinical Problems, 2*(2), 19-27.

292. Dole, V.P. (1989). Interview. In D. Courtwright & J. H. Des Jarlais (Eds.), *Addicts who survived* (pp. 331-343). Knoxville, TN: The University of Tennessee Press.

293. Dole, V.P., & Nyswander, M. E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

294. Dole, V.P., & Nyswander, M. E. (1976). Methadone maintenance treatment: A ten year perspective. *Journal of the American Medical Association*, *235*, 2117-2119.

Service relationships within MM treatment have been inordinately shaped by the regulatory environment and the growing business orientation of OTPs.

> *The "Catch-22" in which the methadone patient, methadone treatment staff, and methadone clinic as an institution are trapped grew out of the conflicting interests that emerged as methadone maintenance was mainstreamed as a treatment modality. On the one hand, there were the needs of the methadone patient and the need for a long-term service relationship based on empathy, trust, and respect. On the other hand, there were concerns about public safety via the potential for methadone diversion. This tension between a milieu of engagement and empowerment versus a milieu of distrust and control left those being served caught between the status of a patient and the status of a prisoner/probationer and left the physician/nurse/counselor caught between their aspirations to serve as healers and onerous, regulatory-imposed policing functions. The result is a demedicalized system of methadone maintenance in which people entering methadone maintenance are treated more like criminals (or recalcitrant children) than patients, within a relational world more dominated by surveillance and control than compassion and choice.*[295]

> *The MM model is based on **control** and **dehumanizes** its "clients" with practices such as observed urinalysis.*[296]

> *I have been on MMT for over 11 yrs now and I can't even remember the last time I had a dirty UA. I have always been a model patient, never caused any problems, or made any formal complaints (even though there were many times I would have if I had not feared retaliation by the clinic owner and doctor).*[297]

To seek help at an OTP requires willingness to surrender central control of one's life to the OTP staff. The person entering the OTP is typically desperate and at the end of his/her rope, having burned all bridges to civility and support in the non-addict world. By entering methadone maintenance pharmacotherapy, patients surrender control over their drug use and their lives to absolute strangers. If that trust is affirmed during the induction period, the patient is likely to remain receptive to maintenance pharmacotherapy. As relationships with clinical staff deepen, the patient is likely to reveal his or her life experience and aspirations to the OTP staff. Establishment of a strong

---

295. Curet, E., Langrod, J., Page, J., & Lowinson, J.H. (1985). Issues of transference in methadone maintenance treatment. *The International Journal of the Addictions, 20*(3), 435-448. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine* (6th edition, pp. 188-214). Thousand Oaks, CA: Sage. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149. White, W. (2009a). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/ recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services.

296. MM patient feedback to authors, May 2010.

297. MM patient feedback to authors, June 2010.

alliance with the patient, beginning with the achievement of optimal dose stabilization in collaboration with the patient, lays the foundation for the larger and more enduring process of biopsychosocial recovery. Recovery-focused helping relationships are distinguished by a shared vision of long-term recovery, a recovery-focused partnership/consultant relationship, and an emphasis on continuity of relational support over time.

ROMM requires abandoning the view that the individual is the sole source of the problem and that the credentialed professional is the source of the solution. The gross power inequities between the patient and OTP clinic must be acknowledged, abuses of such power admitted, and new service relationships formed on a long-term recovery partnership model. Substandard and exploitive care must be exposed and confronted, amends must be made where possible, and policies and practices that punish patient honesty must be abandoned.

There are several measures within MM that can be used to gauge changes in the quality of service relationships over time. These indicators include: 1) measures of therapeutic alliance; 2) surveys of patient attitudes toward OTP staff and OTP services; 3) ethnographic studies of MM patients and the OTP milieu; 4) patient dropout rates during early treatment (first 30 days); 5) rates of dropout during dose and recovery stabilization (first 6 months); 6) discharge status, particularly the rates of administrative discharge and patient termination of services against medical advice; and 7) recovery rates of patients assigned to different counselors or service units.

Positive indicators that an OTP is moving toward recovery-oriented service relationships include increased levels of recovery representation at OTP governance, leadership, and service-delivery levels; respect for patient opinions and preferences via a choice philosophy;[298] reduced incidence of administrative discharges and changes in administrative discharge policies; elevating patient hopes and personal goals (e.g., helping patients weigh the pros and cons of SSI disability support and, where appropriate, achieve productive employment); transitioning patients from professionally developed treatment plans to patient-developed recovery plans; and emphasizing continuity of patient/family contact and support across the stages of long-term recovery.

Ensuring continuity of contact and support might be the Achilles heel of ROMM and the larger movement toward an RM model for all addiction treatment. Such continuity of support in a primary recovery support relationship cannot be ensured in a workforce undergoing constant turnover. Surveys of the addiction treatment workforce reveal high rates (25-50%) of staff turnover and high

298. White, W. (2008e). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

percentages of staff members reporting their intention to leave their current positions in the next five years.[299] There are reports of counselor turnover rates in OTPs as high as 400% per year.[300]

> *Staff turnover is definitely a problem. I got used to the counselor I had when I first started methadone maintenance treatment. I told her all my history, all the dirty details and things I hadn't been able to talk about before. Without me even knowing it was going to happen, she was gone, no goodbye—nothing. Then I had to try and go through all the same stuff again with a new counselor, and for what? Four months later, that one was gone too.*[301]

Ensuring continuity of contact and support within a long-term recovery management framework will require strategies for stabilization of the professional workforce and reliance on others (e.g., volunteers, recovery mutual aid sponsors) to provide such continuity. It is our hope that revitalized, recovery-focused OTPs will make these settings a more fulfilling place to work for physicians, nurses, counselors, other staff, and volunteers.

SERVICE QUALITY/DURATION

Concerns about the quality of MM include six issues: methadone dosing philosophies, the character of addiction counseling, service scope, service duration, discharge status, and the service milieu. All are critical to treatment retention and long-term recovery outcomes.

DOSING PHILOSOPHY/PROTOCOL

Once a patient is admitted into MM treatment, the induction process involves identifying the safest, most appropriate initial dose of methadone. The induction dosing process is fraught with risk. The medication must fulfill the primary objective of alleviating a patient's withdrawal symptoms (if the dose is inadequate, the patient is likely to seek illicit sources of relief), but there is a countervailing danger of lethal toxicity if the medication dose is too high. Ideally, the physician works with each patient, informing the patient of the need to share accurate and complete information regarding past and current use of opioids in order to determine the safest, most effective dose induction schedule for the patient.

Methadone dose is a critical factor in ongoing patient retention and in long-term recovery outcomes,[302] and optimal methadone doses can vary widely from patient to patient based on multiple

299. Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan.* Rockville, MD: Center for Substance Abuse Treatment. McLellan, A.T., Carise, D., & Kleber, H.D. (2003). The national addiction treatment infrastructure: Can it support the public's demand for quality of care? *Journal of Substance Abuse Treatment*, *78*, 125-129. Murphy, D.M., & Hubbard, R.L. (2009). *Understanding America's substance use disorders treatment workforce: A summary report.* National Addiction Technology Transfer Center National Office.

300. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts.* Tucson, AZ: Wheatmark.

301. MM patient feedback to authors, May 2010.

302. Faggiono, F., Vigna-Tagliantiu, F., Versino, E., & Lemma, P. (2003). Methadone maintenance at different dosages for opioid dependence. *Cochrane Database of Systematic Reviews*, Issue 3, Article No.: CD002208. DOI: 10.1002/14651858.CD002208.

factors, including genotypes that influence the rate of methadone metabolism.[303] The likelihood of continued use of heroin and other drugs following enrollment in MM decreases as the daily dose of methadone increases and tolerance is either matched (to the person's prior illicit opioid dose) or built up (to a point where cross-tolerance/blockade to other opioids is established). A significant portion of heroin and other drug use in low-dose MM programs stems from therapeutic (e.g., self-medication of withdrawal symptoms) rather than hedonic motivations.[304] Methadone dose and positive attitudes toward the option of sustained MM treatment are the most critical factors influencing MM retention, which in turn influences long-term recovery outcomes.[305]

The history of MM is filled with intense debates about the superiority of high doses versus low doses of methadone. Anyone with extended tenure in the field of methadone maintenance treatment will recall concerns about "under-dosing," "sub-therapeutic dosing," and "dosing ceilings." Prevailing practice has moved through four stages: 1) high doses (80-120mgd) and long duration in the founding model of MM, 2) arbitrary- and low-dose ceilings (40-60mgd) and time limits on the duration of MM during the 1970s and 1980s, 3) emergence of private clinics known for exceptionally high-dose MM (above 120mgd), and 4) recent trends driven by scientific research and cumulative clinical experience that more closely approximate the founding model.[306] At each dose level of MM, there are patients who do well; the critical factor in this dimension of MM treatment is the need for clinically individualized doses and the recognition that doses may need to be adjusted over time based on the physical, emotional, and social stressors experienced by the patient.[307]

The key benefits of methadone as a pharmacotherapeutic agent in the management of chronic opioid addiction include: (1) cessation of withdrawal symptoms; (2) elimination of drug craving; (3) blocking the euphorigenic effects of other opiates and opiate derivatives; (4) physiological normalization (lack of impairment from intoxication or sedation); and (5) physiological stability due to slow onset, long-acting metabolites (half life of 24-36 hours), and slow elimination due to deep storage in body tissues. Methadone maintenance pharmacotherapy first seeks to eliminate opioid withdrawal symptoms and, by either building or matching tolerance, to identify the patient's optimal dose—the particular methadone dose that maximizes the benefits of methadone in managing the disease of opioid addiction in the individual. Optimal dose stabilization is achieved by maintaining the same benefits from the same optimal dose over time, without interruption. Once optimal dose stabilization is achieved, the patient is neither in a state of withdrawal nor opioid impaired; is considered opioid abstinent (in that the euphorigenic effects of other opioids are blocked); does

303. Tennant, F. (2010). Cytochrome P450 Abnormalities in *Patients Who Require High-Dose Opioids*, The American Journal on the Addiction, 19(4), p. 370.

304. Fatséas, M., Lavie, E., Denis, C., & Auriacombe, M. (2009). Self-perceived motivations for benzodiazepine use among opiate-dependent patients. *Journal of Substance Abuse Treatment*, *37*, 407-411.

305. Caplehorn, J.R. M., Lumley, T., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence*, *52*, 57-61.

306. White, W., & Torres, L. (2010a). Recovery-oriented methadone maintenance: I. Historical context.

307. Senay, E. (2010). Personal communication, February 16, 2010.

not suffer from opioid cravings; and, most important, has acquired the state of stability that is at the heart of the recovery initiation process. Again, these benefits are dependent on each patient's receipt of individualized and optimal doses of methadone.

Caplehorn and colleagues[308] found that patients in abstinence-oriented MM programs (low-dose/low duration philosophy) were more likely to leave treatment (26% more likely in first 6 months and 39% more likely between 18 and 24 months) than patients in maintenance-oriented programs (high-dose/long duration philosophy). Subsequent studies (reviewed below) have affirmed the superiority of higher methadone doses in enhancing treatment retention and outcomes.

MM is unique in the annals of medicine as the only arena in which patients have been denied medication or had their medication dosage lowered as a punishment for clinic rule infractions.[309] The use of medication as a coercive tool has no place in a recovery-oriented approach to the treatment of opioid addiction.

ADDICTION COUNSELING

Recovery outcomes vary significantly across OTPs,[310] and a portion of that variability is attributable to counselor factors.[311] OTPs historically have been staffed with medical personnel charged with the mechanics of MM induction/dosing and counseling staff whose charge has been to facilitate the psychosocial rehabilitation process. Efforts have been made to formulate the special principles and activities that distinguish addiction counseling within the MM treatment setting.[312] However, patients in most OTPs are not afforded the type of counseling that their counterparts receive in other addiction treatment modalities.

Regularly scheduled counseling sessions guided by a theoretical framework of change and overseen by regular clinical supervision, with careful attention to the counseling process and counselor-patient relationship, are uncommon in many OTPs, and most MM patients are not offered a menu of individual, group, marital, or family counseling services.[313] This is not to say that the MM counselor does not wish to provide more counseling or that the counselor has an insignificant role in MM treatment outcomes, but such effects often occur in spite of rather than because of the way the counselor's role is defined in the OTP. MM counselors function more closely to what would be called case managers in other treatment settings. The "counseling" itself is more likely to involve activities such as monitoring urine drops, monitoring patients' behavior in "the line" and at the "dosing

308. Caplehorn, J.R.M., McNeil, D.R., & Kleinbaum, D.G. (1993). Clinic policy and retention in methadone maintenance. *The International Journal of the Addictions, 28*(1), 73-89.

309. Platt, J.J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L. Harrison (Eds.), *Heroin in an age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

310. Ball, J.C., & Ross, A. (1991). The effectiveness of methadone maintenance treatment. New York: Springer-Verlag.

311. Blaney, T. & Craig, R.J. (1999). Methadone maintenance: Does dose determine differences in outcome? *Journal of Substance Abuse Treatment*, *16*(3), 221-228. McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. *The Journal of Nervous and Mental Disease*, *176*(7), 423-430.

312. Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration. Hagman, G. (1994). Methadone maintenance counseling: Definitions, principles, components. *Journal of Substance Abuse Treatment, 11*(5), 405-413. Weiner, H., & Schut, J. (1975). The interaction between counseling and methadone in the treatment of narcotic addicts: The challenge of the counseling relationship. *International Journal of Clinical Pharmacology*, *11*, 292-298. Zweben, J.E. (1991). Counseling issues in methadone maintenance treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

313. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts.* Tucson, AZ: Wheatmark.

window," enforcing clinic rules (e.g., ban on loitering), fielding requests for changes in medication dosage, arranging "guest doses" at other clinics for traveling patients, responding to non-payment of fees, and completing the endless paperwork required to maintain clinic regulatory compliance.

> *Most of the time, you only see your counselor to sign your treatment plan every 3 months. They copy down what they had from the last time, change a few sentences and the dates, and there you have your current treatment plan. I think there should be psychotherapy going on along with MMT, and I thought that is what the counselor was supposed to be for. Not to mention, the clinics I have gone to have all only had ONE counselor for the whole clinic!*[314]

The lack of adequate counseling services is likely to emerge as a source of legal vulnerability for OTPs, as indicated by a recent lawsuit alleging that a major provider of methadone treatment in the U.S. failed to provide the counseling services that it had promised.[315]

Studies to-date confirm an important relationship between MM staff attitudes about MM and retention in treatment.[316] Studies have also found that clinical outcomes of MM patients differ considerably depending on the counselors to whom they are assigned, with neither level of formal education nor recovery status of the counselor predicting the best treatment outcomes.[317] Quantity of counseling also matters. Simpson and colleagues[318] found that increased numbers and/or lengths of counseling sessions for MM patients led to a series of critical effects: decreased in-treatment drug use, increased retention in treatment, and enhanced long-term recovery outcomes. MM patients who communicated with the authors about this monograph often contrasted their experiences with counselors at different clinics.

> *Basically it comes down to this: if I were to relapse and pee dirty for cocaine right now, my current clinic staff* ***would CONGRATULATE themselves on a job well done****—because they caught me. At [my former clinic], my counselor would feel like* ***SHE failed me*** *somehow and she would have been* ***angry and worried FOR ME—not AT me****.*[319]

Prolonged heroin use and its associated lifestyle poisons personal character and interpersonal relationships. As a result, recovery involves not just a cessation of heroin use but also a reconstruction of personal values, personal identity, and relationship to family, friends, and community.[320]

---

314. MM patient feedback to authors, June 2010.

315. Enos, G. (2010). Methadone provider with operations in 18 states sued over lack of services: Suite alleges that clinic does not offer promised therapeutic care. Addiction Professional. Online posting June2, 2010 at http://www.addictionpro.com/ME2/Segments/Publications/Print.asp?Module=Publications

316. Caplehorn, J.R. M., Lumley, T., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence*, *52*, 57-61.

317. McLellan, A.T., Woody, G.E., Luborsky, L., & Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. *The Journal of Nervous and Mental Disease*, *176*(7), 423-430.

318. Simpson, D.D., Joe, G.W., Rowan-Szal, G.A., & Greener, J.M. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse*, *7*, 117-134. Simpson, D.D., Joe, G.W., Rowan-Szal, G.A., & Greener, J.M. (1997). Drug abuse treatment process components that improve retention. *Journal of Substance Abuse Treatment*, *14*(6), 565-572.

319. MM patient feedback to authors, May 2010.

320. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

The biological rationale for MM and the focus on the pharmacotherapeutic aspects of MM have minimized attention to these broader aspects of recovery. These factors have also provided little framework for patients to consider spiritual (including life meaning and purpose) dimensions of the recovery process. Kurtz,[321] in his historical studies of Alcoholics Anonymous and in his writings on spirituality,[322] describes seven experiences that are at the core of the addiction recovery process:

- release (a shedding of mistruths about oneself; surrender; experience of breaking free or being freed; a lessening or loss of burdens);
- gratitude (receptiveness, appreciation, and thanksgiving);
- humility (acceptance of imperfection, being free of comparisons, honesty, balance);
- tolerance (experience of mutual vulnerability; openness to difference; compassion);
- forgiveness (shedding the past; letting go of resentment, anger, and sadness);
- awe and wonder (being humbled before something of great power and beauty); and
- compassion (recognizing the woundedness of others; desire to share awe and joy with others; affirmation of life in the face of pain and loss).

Rarely have mainstream MM patients had such issues explored in a counseling process. They have not been afforded the scope and intensity of educational and counseling experiences routinely provided to those in other addiction treatment modalities.

There are several matters over which the methadone counselor has either exclusive or considerable control that can adversely affect the life of a methadone patient. These include how often and at what time the patient must come to the OTP for daily dosing and whether, or under which, circumstances the patient can earn "take-home" medication bottles and how many they can earn. Denying a patient take-home medication, insisting the patient attend the OTP daily, and limiting the time or hours in which the patient can receive his/her daily dose profoundly affects the patient's self-esteem and his or her capacity to take on or to fulfill family, work, school, and travel obligations. Patients can request take-home privileges for special occasions, vacations, or in the case of a hardship, through a system in which there is much counselor discretion but little patient recourse in response to denial. Patients who find the courage to challenge staff decisions or actions often do so in fear of retaliatory action. The counselor relationship carries the most weight in such decision-making.

---

321. Kurtz, E. (1979). *Not-God: A history of Alcoholics Anonymous*. Center City, MN: Hazelden (revised and expanded edition, 1991). Kurtz, E. (1999). *The collected Ernie Kurtz*. Wheeling, WV: Bishop of Books.

322. Kurtz, E., & Ketcham, K. (1992). *The spirituality of imperfection*. New York: Bantam Books.

Under the current MM system, patients achieve substantial improvements related to heroin use and lifestyle stability, but many continue to experience difficulties with a variety of drugs (e.g., opioids, cocaine, benzodiazepines, alcohol) and remain economically dependent and socially unproductive—still isolated and socially estranged from the mainstream of community life.[323] The founders of methadone maintenance were quite explicit about its limitation in addressing drug problems other than heroin (or other opioid) addiction.

> *…methadone has no unique value in the treatment of non-opiate addictions—alcohol, cocaine, sedatives and tranquilizers—or smoking. The therapeutic environment of a good methadone clinic can help in dealing with these complicating problems, but credit for improvement in these areas must go mainly to persistent, supportive counseling.*[324]

MM patients have not been afforded the intensity of education and counseling to address these larger issues of global health and functioning that mark other addiction treatment modalities—in part because of the high ratios of patients to counselors that typify OTPs.

Changing the counseling relationship to a sustained partnership grounded in the need to manage a chronic disease over the patient's lifetime will require orienting patients in the fundamentals of long-term recovery from opioid addiction. Patients will need to understand such concepts as chronic disease, optimum dose stabilization, recovery management, recovery partnership, patient-centered care, and recovery planning. Rather than being passive recipients of new models of care, patients in ROMM will be required to become fully engaged in shaping these new approaches to long-term recovery management. This orientation, education, and participation process should provide new inspiration and confidence for patients who have been quieted by shame, misinformation, and fear of reprisal for speaking out about the inadequacy of current treatment services. In the same vein, it will be important to acknowledge that not all patients need continued counseling and that periodic recovery checkups might replace required counseling when the latter serves only as a meaningless ritual of regulatory compliance for patients who have reached a high degree of recovery stability. We are arguing simultaneously for more and less counseling in the OTP milieu based on the needs of the particular patient.

---

323. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74.

324. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

SCOPE OF ANCILLARY SERVICES

Ancillary services in methadone treatment include resources for identifying and treating co-occurring medical, psychiatric, and illicit substance use problems; vocational/employment services; legal services; and peer-based recovery support services. Several studies have been conducted to assess whether or not the scope of ancillary services influences post-treatment recovery outcomes.

- McLellan and colleagues[325] found that MM patients who received enhanced services (medical/psychiatric care, family counseling, and employment services) achieved better treatment outcomes than patients who received only methadone or methadone plus counseling.
- McLellan and colleagues[326] found that patients who received supplemental social services (case management, medical screening, housing assistance, parenting classes, and employment services) achieved better outcomes (less substance use, fewer medical/psychiatric problems, and better social functioning) than patients who received only core MM services.
- Friedmann and colleagues[327] found that ancillary on-site medical services enhanced post-treatment substance use outcomes.
- Berkman and Wechsberg[328] confirmed that a higher percentage of MM patients received ancillary services when these services were provided on-site at the MM clinic rather than provided through off-site referral.[329]
- Kraft and colleagues[330] conducted a study of varying intensity levels of ancillary services in MM and found that abstinence rates were highest for those receiving the highest intensity of supplemental services, but that methadone plus counseling was the most clinically effective and cost-effective threshold of service provision.
- Avants and colleagues[331] compared two 12-week formats for delivering intensified MM services and found that outpatient MM amplified with ancillary services generated the same outcomes as a more intense day treatment format, and for less than half the cost.

The need for legal and other advocacy services is rarely mentioned in the professional literature on MM, despite the many legal issues faced by patients seeking MM and the variety of discrimination issues that they face. Such services would be a welcomed addition to the OTP service menu.

---

325. McLellan, A.T., Arndt, I.O., Metzger, D.S., Woody, G.E., & O'Brien, C.P. (1993). The effect of psychosocial services in substance abuse treatment. *Journal of the American Medical Association, 269*, 1953-1957.

326. McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, *93*(10), 1489-1499.

327. Friedmann, P.D., Zhang, A., Hendrickson, J., Stein, M.D., & Gerstein, D.R. (2003). Effect of primary medical care on addiction and medical severity in substance abuse treatment programs. *Journal of General Internal Medicine*, *18*, 1-8.

328. Berkman, N.D., & Wechsberg, W.M. (2007). Access to treatment-related and support services in methadone treatment. *Journal of Substance Abuse Treatment, 32*, 97-104.

329. Umbricht-Schneiter, A., Ginn, D.H., Pabst, K.M., & Bigelow, G.E. (1994). Providing medical care to methadone clinic patients: Referral vs. on-site care. *American Journal of Public Health*, *84*, 207-210.

330. Kraft, M.K., Rothbard, A.B., Hadley, T.R., McLellan A.T., & Asch, D.A. (1997). Are supplementary services provided during methadone maintenance really cost-effective? *American Journal of Psychiatry, 154*(9), 1214-1219.

331. Avants, S.K., Margolin A., Sindelar J.L., Rounsaville B.J., Schottenfeld, R., & Stine S. (1999). Day treatment versus enhanced standard methadone services for opioid- dependent patients: A comparison of clinical efficacy and cost. *American Journal of Psychiatry, 156*(1), 27-33.

Some early treatment systems, such as the Illinois Drug Abuse Program, provided such legal services as an ancillary service for MM patients.[332]

Expanding the range of services provided is congruent with the ROMM understanding that recovery encompasses global health and positive community integration. Further reflecting this understanding is ROMM's family orientation. Family-focused services have not been a part of mainstream MM treatment services, with only the youngest of MM patients likely to have their family members consistently involved in the treatment process.[333] Research in the past decade confirms three critical findings in this area: 1) family relationships are profoundly influenced by addiction,[334] 2) these relationships exert a critical influence on recovery outcomes,[335] and 3) drug-free family members can be mobilized to participate in the treatment of MM patients.[336]

Pilot efforts to provide more family-focused services within OTPs have been evaluated positively. Dawe and colleagues[337] evaluated the Parents under Pressure program and found that a family-focused service intervention attached to MM enhanced parental functioning, improved parent-child relationships, reduced the risk of child abuse, reduced behavior problems of children of MM patients, and decreased parental substance use. Fals-Stewart, O'Farrell, and Birchler[338] tested the value of individual versus couples-focused MM counseling services and found that those patients receiving behavioral couples therapy experienced less substance use and enhanced quality of family relationships. Greif and Drechsler[339] have outlined how parenting training groups can address some of the parenting issues faced by MM patients, e.g., difficulty providing consistent daily structure, guilt from past acts of neglect, sabotage of parenting by one's own parents, anger from children due to addiction/recovery history, and the special challenges of raising adolescents. Grella and colleagues found that mothers treated in programs with a high level of family-focused services were twice as likely to experience successful reunification with their children as mothers treated in programs rated low in such services.[340] Given the widespread community misunderstandings about methadone maintenance treatment, educational and support services for parents, siblings, intimate partners, children, and friends of the MM patient would seem to be particularly indicated to prevent sabotage of the patient's recovery efforts and to mobilize support for recovery initiation and maintenance.

One of the issues of considerable importance in ROMM is the need to provide treatment that has the potential of breaking intergenerational cycles of alcohol and other drug problems.[341] Haggerty

---

332. Senay, E. (2010). Personal communication. May 20, 2010.

333. Guarino, H.M., Marsch, L.A., Campbell, W.S., Gargano, S.P., Haller, D.L., & Solhkhan, R. (2009). Methadone maintenance treatment for youth: Experience of clients, staff and parents. *Substance Use and Misuse*, *44*(14), 1979-1989.

334. See, for example, McMahon, T.J., Winkel, J.D., & Rounsaville, B.J. (2008). Drug abuse and fathering: A comparative study of men enrolled in methadone maintenance. *Addiction*, *103*(2), 269-283.

335. Heinz, A.J., Wu, J., Witkiewitz, K, Epstein, D.H., & Preston, K.L. (2009). Marriage and relationship closeness as predictors of cocaine and heroin use. *Additive Behaviors*, *34*(3), 258-263. Knight, D.K., & Simpson, D.D. (1996). Influences of family and friends on client progress during drug abuse treatment. *Journal of Substance Abuse*, *8*(4), 417-429. Powers, K.I., & Anglin, M.D. (1996). Couples' reciprocal patterns in narcotic addiction: A recommendation on treatment strategy. *Psychology and Marketing*, *13*(8), 769-783.

336. Kidorf, M., Brooner, R.K., & Kinh, V.L. (1997). Motivating methadone patients to include drug-free significant others in treatment: A behavioral intervention. *Journal of Substance Abuse Treatment*, *14*(1), 23-28.

337. Dawe, S., & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*, *32*(4), 381-390. Dawe, S., Harnett, P.H., Rendalls, V., & Staiger, P. (2003). Improving family functioning and child outcome in methadone maintained families: The Parents Under Pressure Programme. *Drug and Alcohol Review*, *22*(3), 299-307.

338. Fals-Stewart, W., O'Farrell, T.J., & Birchler, G.R. (2001). Behavioral couples therapy for male methadone maintenance patients: Effects on drug-using behavior and relationship adjustment. *Behavior Therapy*, *32*(2), 391-411.

339. Greif, G. L., & Drechsler, M. (1993). Common issues for parents in a methadone maintenance group. *Journal of Substance Abuse Treatment, 10,* 339-343.

340. Grella, C.E., Needell, B., Shi, Y., & Hser, Y-I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, *36*(3), 278-293.

341. White, W. L., & Chaney, R.A. (2008). *Intergenerational patterns of resistance and recovery within families with histories of alcohol and other drug problems: What we need to know.* Retrieved from www.facesandvoicesofrecovery.org.

and colleagues[342] evaluated a program (Families Facing the Future) that provided parent training workshops and home-based family support services. They found that such services reduced the risk of substance use disorders among the male children of MM patients. We envision a day when a full range of family-, parent-, and child-focused services will be an integral component of mainstream methadone maintenance. Such services might include recovery-focused family education classes, family counseling, family support groups, parenting training, in-home family support services, family night social events, a children's program (counseling, prevention, and early intervention), and inclusion of family members in leadership roles in patient councils and alumni associations.

SERVICE DURATION

MM was conceptualized as a chronic disease by founders who envisioned that many if not most people treated for chronic heroin addiction would require prolonged if not lifelong methadone pharmacotherapy, analogous to the way in which many patients with diabetes or hypertension receive prolonged medication support. This conclusion was based on the finding in the earliest study of MM patient outcomes that less than 10% of patients were found to be "doing well" after cessation of methadone pharmacotherapy.[343] Through this and subsequent studies, MM was defined as corrective rather than curative.

> *It may be necessary for [MM] patients to remain in treatment for indefinite periods of time, possibly for the duration of their lives.*[344]

> *…we don't see the need of getting people off [methadone maintenance] treatment any more than you'd try to get people off treatment from insulin…*[345]

From the beginning, there were some MM patients who sustained abstinence-based recoveries following cessation of MM, but Dr. Dole cautioned that "an obsessive preoccupation with abstinence is self-defeating, leading to low-dose programs (which fail to stabilize the patient), premature discharge from treatment and low self-esteem if long-term abstinence seems unattainable."[346] He further noted that:

> *…methadone patients are not necessarily committed to a lifelong dependence on the medication… The key to this result [sustained abstinence following termination of methadone maintenance] is the realization that the most important objective in treatment of an addict is support of good health and normal function. This may*

342. Haggerty, K. P., Skinner, M., Fleming, C. B., Gainey, R. R., & Catalano, R. F. (2008). Long-term effects of the Focus on Families project on substance use disorders among children of parents in methadone treatment. *Addiction*, *103*(12), 2008-2016.

343. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364. Lowinson, J.H., Berle, B., & Langrod, J. (1976). Detoxification of long-term methadone patients: Problems and prospects. *The International Journal of the Addictions*, *11*(6), 1009-1018.

344. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364.

345. Kreek, M.J. (2001). Myths about heroin addiction. In B. Seega (Producer), *The Health Report*. Sydney, Australia: Health Report. Retrieved June 23, 2003 from http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s391783.htm.

346. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

> *or may not require continuation of maintenance pharmacotherapy… Available data suggest that the longer a patient continues in a maintenance program that provides adequate doses (e.g., five years or more), the greater his or her probability of permanent abstinence after termination of treatment… the neurochemical adaptations produced by thousands of heroin injections… are capable of gradual repair in some cases under the steady conditions of methadone maintenance.*[347]

Dole also noted that the potential for post-MM abstinence was linked to the issue of methadone dose.

> *A wrong belief exists in the general public and in the medical profession, and even, I'm sorry to say, in methadone programs around the world. This is the illusion that by giving a very low dose [of methadone], you facilitate the evolution of this treatment to complete abstinence. The opposite is really the truth.*[348]

As reflected in Dole's observations, sustained recovery after tapering requires the achievement of two time-dependent processes within MM: 1) neurophysiological healing of the brain, and 2) a larger process of healing the physical, psychological, and social impairments produced by chronic heroin addiction. When such healing has not taken place, successful tapering from MM is unlikely. Unfortunately, we currently know a great deal more about the neuropathology and psychosocial pathologies of addiction than we know about the processes of neurophysiological and psychosocial healing in long-term addiction recovery.[349] The duration of MM declined throughout the 1970s and 1980s in tandem with the growing professional, family, and community expectations that MM should be as short as possible. Opioid addiction then became the only chronic disease in which patients were shamed and stigmatized for long-term medication adherence and denied pride in the achievement of sustained recovery stabilization—in marked contrast to the experience of those celebrating the length of their recoveries in AA, NA, and treatment alumni association meetings.

There have been contentious debates for more than four decades about how long a patient should be maintained on methadone, but the reality is that most patients admitted to MM voluntarily or involuntarily leave in less than a year, frequently relapse following their discharge, and are often readmitted to MM or other treatment in what becomes a long, complex career of serial episodes of acute, treatment-facilitated stabilization. In spite of theoretical foundations supporting the efficacy of prolonged if not lifelong MM for most patients, studies beginning in the 1980s found that 80-100% of MM patients expect to taper from methadone at some time in the future and to continue their

---

347. Dole, V.P. (1994b). What we have learned from three decades of methadone maintenance treatment. *Drug and Alcohol Review*, *13*, 3-4.

348. Dole, V.P. (1994a). Addiction as a public health problem. *Alcoholism: Clinical and Experimental Research*, *15*(5), 749-752.

349. Erickson, C., & White, W. (2009). Commentary: The neurobiology of addiction recovery. *Alcoholism Treatment Quarterly*, *27*(3), 338-341.

recovery without medication.[350] Great anxiety, if not outright phobia, is common as the time to initiate tapering approaches as a result of a personal goal or one imposed by one's treatment program.[351] These anxieties are related to folklore about the difficulty of tapering, prior failed efforts at tapering, and lack of contact with patients who have successfully sustained recovery after tapering.[352] Such emotional distress may account for the fact that the majority of patients who begin to taper do not complete the tapering process and either return to maintenance treatment or drop out of treatment.[353] The rates of success have improved with the advent of new pharmacological adjuncts to aid the tapering process.

The majority of patients who are discharged from MM eventually return to heroin or other illicit opioid use,[354] with first-year rates of resumed opioid use approaching or exceeding 50%, followed by a longer-term progressive decay in abstinence rates.[355] Also striking is the speed at which relapse occurs. In a follow-up study of tapered MM patients by Gossop and colleagues,[356] 42% of those who relapsed did so within one week of reaching zero dose of methadone, and 71% of this group relapsed within six weeks. Post-treatment abstinence rates from heroin range from 8% to 33% (based primarily on self-report and varying by length of follow-up period),[357] and treatment re-admission rates are high.[358]

The best single predictors of post-MM abstinence from heroin are longer periods of time in treatment, discharge status of treatment completion as planned, and employment during and after treatment.[359] The latter is of particular significance in light of data revealing that only 26% of MM patients discharged from treatment in 2005 were employed at the time of discharge (46% were identified as not in the labor force, and 27% were identified as unemployed—rates similar to those of all patients discharged from addiction treatment in the U.S.).[360]

Patients who remained continuously in MM or who completed a sustained period of MM have post-treatment recovery outcomes superior to those of patients completing only methadone-assisted detoxification and patients who cycle in and out of MM.[361] The shorter the first treatment period in MM, the greater the likelihood of treatment readmission.[362] Based on post-treatment recovery outcomes, the minimum clinically optimal amount of time in MM has been defined as one year of continuous MM treatment,[363] with some researchers concluding that two years constitutes the minimum optimal MM treatment duration.[364] Clinical outcomes deteriorate with decreased length of time in treatment, with patients who spent less than three months in MM treatment

350. Langrod, J., Des Jarlais, D.C., Alksne, L., & Lowinson, J. (1983). Locus of control and initiation of detoxification among male methadone maintenance patients. *International Journal of the Addictions*, *18*(6), 783-790. Stancliff, S., Myers, J.E., Steiner, S., & Drucker, E. (2002). Beliefs about methadone in an inner city methadone clinic. *Journal of Urban Health*, *79*, 571-578.

351. Milby, J.B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422.

352. Gold et al. found that only 48% of MM patients knew someone who had successfully tapered his/her methadone dose to zero compared to 83% of MM staff. Both staff and patients were pessimistic about the odds of tapering success: 14% estimated success rate by patients and 10% estimated success rate by MM staff. Gold, M.L., Sorensen, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment, 5*, 37-44.

353. Kleber, H.D. (1977a). Detoxification from methadone maintenance: The state of the art. *International Journal of the Addictions, 12,* 807-820. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine*, *68*, 62-74.

354. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment (MMT): A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine, 68*, 62-74.

355. Gold, M.L., Sorensen, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment, 5*, 37-44. Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422.

356. Gossop, M., Green, L., Phillips, G., & Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment. *British Journal of Psychiatry*, *154*, 348-353.

357. Ball, T.C., & Ross, A. (1991). *The effectiveness of methadone treatment.* New York: Springer-Verlag. Dole, V. P., & Joseph, H. (1978). Long-term outcome of patients treated with methadone maintenance. *Annals of the New York Academy of Science*, *311*, 173-180. Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422.

358. Newman, R.G., Tytun, A., & Bashkow, S. (1976). Retention of patients in the New York City Methadone Maintenance Treatment Program. *International Journal of the Addictions, 11*(5), 905-931.

359. Des Jarlais, D.C., Joseph, H., Dole, V.P., & Schmeidler, J. (1983). Predicting post-treatment narcotic use among patients terminating from methadone maintenance. *Journal of Alcohol and Substance Abuse*, *2*(1), 57-68. Ward, J., Mattick, R.P., & Hall, W. (1998). How long is long enough? Answers to questions about the duration of methadone maintenance

experiencing only minimal long-term improvement.[365] Hubbard and colleagues[366] found that MM had substantially higher retention rates (68% after three months) than outpatient counseling without methadone (36%) or residential programs without methadone (45%).

In spite of the importance of treatment retention and duration, one-year retention rates in most programs are less than 50%,[367] but this can vary considerably by program. Kreek[368] has reported retention rates ranging from 60-85% in "good programs"—those providing optimum methadone doses, on-site counseling, and ancillary medical and psychiatric services. In 2005, the average length of time in treatment for patients discharged from opioid replacement therapy in the United States was 245 days.[369] The majority of MM patients who spend less than a year in their first treatment episode will return to treatment for multiple treatment episodes.[370] Problems related to the retention of stabilized patients include pressure from self and others to "get off methadone"; resentment toward program rules that are perceived as restrictive, paternalistic, and humiliating[371]; and legislative or regulatory efforts to set arbitrary limits on the length of time a patient can remain in methadone maintenance.[372]

Most MM patients cycle in and out of treatment via 5 stages: 1) enter treatment in a state of crisis, 2) extract substantial benefits from treatment, 3) leave treatment during a period of recovery stability, 4) resume opioid use and clinically deteriorate following treatment discharge, and 5) re-enter treatment in crisis but with less severity than in earlier admissions.[373] Of patients discharged from OTPs in the United States in 2005, 77% had been in treatment before and 24% had five or more prior treatment episodes.[374] Recycling in and out of treatment is a dominant pattern in MM,[375] as it is in the larger addiction treatment arena.[376]

In conclusion, discharge from MM is accompanied by significantly increased risk or resumption of illicit opioid use and death.[377] Like medication-based treatments for other chronic health conditions, methadone is effective as a medication only as long as it continues to be used as prescribed. MM policies that lower patient retention rates, even when done with the noblest of intentions (promoting abstinence from all opioids, including methadone), heighten patient risk for re-addiction, infectious disease, resumption of addiction-related criminality, arrest and incarceration, and death.[378] Tapering from MM is most conducive to long-term recovery outcomes when it is voluntary, recommended by MM staff based on rehabilitation progress, phased over an extended period of time, and accompanied by increased professional and peer support

---

treatment. In J. Ward, R.P. Mattick, & W. Hall (Eds.), *Methadone maintenance treatment and other opioid replacement therapies* (pp. 305-336). Amsterdam: Harwood Academic.

360. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

361. Kosten, T.R., Rounsaville, B.H., & Kleber, H.D. (1986). A 2.5 year follow-up of treatment retention and reentry among opioid addicts. *Journal of Substance Abuse Treatment*, *3*, 181-189.

362. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment: Participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

363. Greenfield, L., & Fountain, D. (2000). Influence of time in treatment and follow-up duration on methadone treatment outcomes. *Journal of Psychopathology and Behavioral Assessment, 22*(4), 353-364. National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment* (NIH Publication No. 00-4180). Rockville, MD: National Institute on Drug Abuse. Retrieved from http://www.nida.nih.gov/PODAT/PODATIndex.html. Simpson, D.D., Brown, B.S., & Joe, G.W. (1998). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 294-307.

364. Kleber, H.D. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305. Leshner, A. (2000). *Keynote address.* Presented at the National Institute on Drug Addiction Blending Conference, Weston Hotel, Los Angeles, CA.

365. NIH. (1998). Effective medical treatment of opiate addiction: National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. *Journal of the American Medical Association, 280*(22), 1936-1943. Retrieved from http://odp.od.nih.gov/consensus/cons/108/108_statement.htm.

366. Brands, B., & Brands, J. (Eds.) (1998). Methadone maintenance: A physician's guide to treatment. Toronto: Addiction Research Foundation, Centre for Addiction and Mental Health. Hubbard, R.L., Marsden, M.E., Rachal, J.V., Harwood, H.J., Cavanaugh, E.R., & Ginzburg, H.M. (1989). *Drug abuse treatment: A national study of effectiveness.* Chapel Hill, NC: University of North Carolina Press.

367. Deck, D., & Carlson, M.J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60.

368. Kreek, M.J. (2000). Methadone-related agonist therapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of the New York Academy of Science*, *909*, 186-216.

services.[379] Even with such supports, post-treatment relapse rates are high.[380] A key predictor of the degree of effectiveness of MM (like that of other addiction treatment modalities) is duration of active participation in treatment, with longer periods of retention associated with better long-term recovery outcomes.[381] Promising practices to increase MM retention include higher, individualized methadone doses to ensure optimum stabilization, training and supervision to strengthen the counselor-patient relationship, expanding the service menu, and exposing patients to successful patients and former patients in stable, successful long-term recovery.[382]

A rarely discussed issue related to patient retention in MM is that of fees charged to patients. There are three types of OTPs in terms of payment for medication and other services: 1) for-profit OTPs, such as the large networks of CRC and Colonial clinics, whose fees are fully paid by a combination of the patient and his/her insurance company; 2) hybrid clinics that charge fees but on a sliding scale based on the patient's ability to pay; and 3) OTPs whose costs are fully covered by Medicaid or various state services, with no direct costs incurred by the patients. Of the 1,132 OTPs in the United States surveyed in 2008, only 34% of OTPs offered free treatment for patients who could not pay for their treatment, and only 51% offered a sliding fee scale.[383]

During times of personal and widespread financial distress, the issue of fees can undermine patient retention. Patients who are "financially noncompliant" are at high risk of voluntarily or involuntarily terminating MM—the latter christened "fee-tox" by MM patients.[384] It is most often the working poor who are shut out of methadone because of inability to pay. Strategies with the potential of addressing the fee-tox issue include: 1) establishing funds that would award patients low-interest loans to sustain their treatment while they rebuilt their financial stability, 2) lowering fees for financially distressed patients, and 3) extending the tapering period in hopes that the patient will be able to catch up on the balance due. MM patients who communicated with the authors about this monograph were particularly incensed by those clinics they perceived to be more concerned with financial outcomes than recovery outcomes.

> *The clinic I go to is a true "business" in every sense of the word. It is not anything close to "therapeutic," it's just shoveling out methadone and we keep taking it. They think money, talk money, and probably even "dream" money… Until the day all clinics are ran as "therapy" centers, things will never change.*[385]

369. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

370. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment: Participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

371. Lowinson, J.H., Berle, B., & Langrod, J. (1976). Detoxification of long-term methadone patients: Problems and prospects. *The International Journal of the Addictions*, *11*(6), 1009-1018.

372. Clark, H.W. (2010). Pennsylvania may limit methadone treatment to one year. *Alcoholism & Drug Abuse Weekly*, 22(25), 4-6.

373. Kosten, T.R., Rounsaville, B.H., & Kleber, H.D. (1986). A 2.5 year follow-up of treatment retention and reentry among opioid addicts. *Journal of Substance Abuse Treatment*, *3*, 181-189.

374. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

375. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment: Participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

376. Dennis, M.L., Scott, C.K., Funk, R., & Foss, M.A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*, S51-S62.

377. Magura, S., & Rosenblum, A. (2001). Leaving methadone treatment: Lessons learned, lessons forgotten, lessons ignored. *Mount Sinai Journal of Medicine, 68*, 62-74. Woody, G., Kane, V., Lewis, K., & Thompson, R. (2007). Premature deaths after discharge from methadone maintenance: A replication. *Journal of Addiction Medicine*, *1*(4), 180-185.

378. Caplehorn, J.R.M., McNeil, D.R., & Kleinbaum, D.G. (1993). Clinic policy and retention in methadone maintenance. *The International Journal of the Addictions, 28*(1), 73-89.

379. Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362. Milby, J. B. (1988). Methadone maintenance to abstinence: How many make it? *Journal of Nervous and Mental Disorders*, *176*(7), 409-422. Platt, J. J., Widman, M., Lidz, V., & Marlowe, D. (1998). Methadone maintenance treatment: Its development and effectiveness after 30 years. In J.A. Inciardi & L.Harrison (Eds.), *Heroin in an age of crack-cocaine* (pp. 160-187). Thousand Oaks, CA: Sage.

The private clinics I have attended charge anywhere from $80-$95 a week in addition to separate charges for all other services and they do not take private insurance or Medicaid and are CASH ONLY. If you are late on fees, they will detox you within a matter of weeks. They take no excuses for getting behind and do not let you "charge" and catch up at a later date, even if you are having a financial hardship. They can go up on their prices any time they want; they can give you a decrease on your dose anytime they want. They can make you jump through all these hoops like a show dog and you just have to take it![386]

DISCHARGE STATUS AND RECOVERY OUTCOMES

A discharge status of treatment completion signals that both the MM patient and OTP staff members have collaborated on a planned process of tapering from methadone and have a plan for sustained recovery self-management following the cessation of methadone pharmacotherapy. The process involves substantial progress in psychosocial rehabilitation as well as successful tapering off methadone. Treatment completion has generally served as an intermediary measure of treatment outcome, with patients who have completed treatment having better post-treatment outcomes than those discharged for other reasons (e.g., dropping out, administrative discharge, incarceration, or transfer).[387]

The scientific and clinical literature on MM is filled with reports on the MM patient induction process, but it is striking how little focus has been paid to the process of patient disengagement from MM (beyond a focus on dosing protocols for tapering). Of MM patients discharged from outpatient opioid replacement therapy in the United States in 2005, only 11% completed treatment as planned; 45% dropped out; 17% were transferred to other programs; 13% were terminated by the program; and 15% were discharged for other reasons.[388] Opioid replacement therapy has the lowest completion rate of all addiction treatment modalities.[389] Much greater attention needs to be focused on the process through which patients disengage from participation in MM and the supports that best sustain recovery without the aid of medication or, when needed, speed the re-initiation of medication-assisted recovery.

Patients may be "administratively discharged" (also referred to as "involuntary discharge" or "therapeutic termination") from OTPs for continued drug use, violence or threats of violence, failure to pay fees, selling drugs, loitering, or repeated violation of program rules. We find the practice

380. Sorensen, J. L., Trier, M., Brummett, S., Gold, M., & Dumontet, R. (1992). Withdrawal from methadone maintenance: Impact of a tapering network support program. *Journal of Substance Abuse Treatment*, *9*, 21-26.

381. Sees, K.L., Delucchi, K.L., Masson, C., Rosen, A., Clark, H., Robillard, H., Hall, S.M. (2000). Methadone maintenance vs. 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. *Journal of the American Medical Association, 283*(10), 1303-1310.

382. Simpson, D.D., Brown, B.S., & Joe, G.W. (1998). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 294-307.

383. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2010). *The N-SSATS Report. Overview of opioid treatment programs within the United States: 2008*. January 28, National Survey of Substance Abuse Treatment Services.

384. Berry, L.C. (2007). *In$ide the methadone clinic indu$try: The financial exploitation of America's opiate addicts*. Tucson, AZ: Wheatmark.

385. MM patient feedback to authors, May 2010.

386. MM patient feedback to authors, May 2010.

387. Hubbard, R.L., Craddock, S.G., & Anderson, J. (2002). Overview of 5-year follow-up outcomes in the Drug Abuse Treatment Outcome Studies (DATOS). *Journal of Substance Abuse Treatment, 25*, 125-134. Wallace, A. E., & Weeks, W. B. (2004). Substance abuse intensive outpatient treatment: Does program graduation matter? *Journal of Substance Abuse Treatment*, *27*, 27-30.

388. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

389. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

of discharging patients for continued drug use particularly onerous. There is no other health care sector where one can be punished and extruded for exhibiting a symptom of the disorder being treated. In other settings, symptom continuation or a resurgence in symptoms calls for reassessment and refinement of treatment procedures, rather than the expulsion of the patient from treatment.[390] Dr. Robert Newman describes this paradox:

> *Patients also face termination [of MM] for a host of other reasons that are without parallel in the medical management of disease. For instance, renal dialysis would never be stopped because a patient smoked marijuana, or crack, or used other illicit substances. Nor would those suffering from hypertension, diabetes, arthritis, glaucoma, schizophrenia or any other illness be abandoned because they used drugs. How ironic, then, that most methadone programs, whose express mission is to treat addiction, refuse to tolerate patients who demonstrate signs and symptoms of drug use…Medical care should not be withheld except for strictly medical reasons.*[391]

The risks of administrative discharge from MM are compounded in programs that impose mandatory waiting periods before patients who were administratively discharged can be considered for readmission. In some OTP studies, the rate of administrative (involuntary) discharge exceeds 50% of all discharges.[392] Of the total discharges from OTPs in 2005, 13% were administrative discharges.[393] Disciplinary discharges appear to be more prevalent when OTPs have limited capacity, have high counselor caseloads, and experience pressure for admission of persons from their waiting lists.[394]

At least one study claimed evidence of reduced drug use and increased retention in programs that expel patients exceeding particular levels of drug use,[395] but these benefits usually accrue at the expense of "terminating" those patients most in need of sustained and intense clinical management.[396] Involuntary discharge from MM is associated with rapid clinical deterioration, e.g., re-addiction, criminal activity, disease exposure/transmission, and alienation from family and community.[397] There is no evidence of "therapeutic" effects of administrative discharge for the patient being discharged, in spite of anecdotal reports of such effects.[398] Patients who are administratively discharged from MM are at increased risk of post-treatment relapse and death;[399] patients subjected to involuntary tapering and termination have the worst post-discharge recovery outcomes.[400]

---

390. 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.

391. Newman, R.G. (2000). Addiction and methadone. *Heroin Addiction & Related Clinical Problems, 2*(2), 19-27.

392. Zanis, D.A., McLellan, A.T., Alterman, A.I., & Cnaan, R.A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry*, *153*, 1095-1096.

393. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008). *Treatment Episode Data Set (TEDS): 2005. Discharges from substance abuse treatment services* (DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

394. Deck, D., & Carlson, M.J. (2005). Retention in publicly funded methadone maintenance treatment in two Western states. *Journal of Behavioral Health Services & Research*, *32*(1), 43-60. Stewart, D., Gossop, M., & Marsden, J. (2004). Increased caseloads in methadone treatment programs: Implications for the delivery of services and retention in treatment. *Journal of Substance Abuse Treatment*, *27*(4), 301-306.

395. McCarthy, J.J., & Borders, O.T. (1985). Limit setting on drug abuse in methadone maintenance patients. *American Journal of Psychiatry*, *142*, 1419-1423.

396. Kahn, R.B. (1992). Methadone maintenance treatment: Impact of its politics on staff and patients. *Journal of Psychoactive Drugs*, *24*(3), 281-283.

397. Britton, B.M. (1994). The privatization of methadone maintenance: Changes in risk behavior associated with cost related detoxification. *Addiction Research & Theory*, *2*(2), 171-181. Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362. Zanis, D.A., McLellan, A.T., Alterman, A.I., & Cnaan, R.A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry, 153*, 1095-1096.

398. Tozman, S., & DeJesus, E. (1981). The positive side of administrative discharge (in a drug program). *The International Journal of the Addictions*, *16*(1), 135-139.

399. Zanis, D.A., & Woody, G.E. (1998). One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence, 52*(3), 257-260.

400. Knight, K.R., Rosenbaum, M., Irwin, J., Kelley, M.S., Winger, L., & Washburn, A. (1996). Involuntary versus voluntary detoxification from methadone maintenance treatment: The importance of choice. *Addiction Research, 3*(4), 351-362.

Ward and colleagues[401] reviewed the issue of administrative discharge from MM programs and concluded that non-punitive approaches were more effective. Belding, McLellan, Zanis, & Incmikoski's[402] study of MM "non-responders" suggested three broad strategies to address continued opioid and other drug use: 1) increasing methadone doses to optimal levels (43% of their non-responders were below 80 mgd), 2) increasing internal motivation for cessation of drug use via counseling, and 3) creating external contingencies that rewarded positive treatment participation.

THE MM MILIEU: CULTURE OF ADDICTION OR CULTURE OF RECOVERY?

> *The current clinic structure keeps recovering addicts in contact with people who are still using—a fatal flaw because the MM program is itself immersed within the drug scene, not a step away from it. One gets off the dope line and into another line—behind the same folks.*[403]

There are several key points related to the relationship between the addiction treatment milieu and recovery outcomes.

- For persons enmeshed in illicit drug cultures, the transition from addiction to recovery is a journey between two physical and social worlds—from a culture of addiction to a culture of recovery, each with its own distinct cultural trappings, e.g., language, values, dress, symbols, rituals, roles, social pecking orders, etc.
- Patients who are deeply enmeshed in illicit drug cultures bring the trappings of these cultures with them when they enter the treatment milieu.
- The best single predictor of continued drug use during MM is the presence of drug users within the social and intimate relationships of the patient.[404]
- Effective addiction treatment involves facilitating the patient's physical and social disengagement from the culture of addiction and shedding of the trappings of that culture, as well as guiding the patient into a relationship with an alternative culture of recovery.
- The presentation of drug culture trappings in the treatment milieu reinforces continued drug use and undermines recovery initiation and maintenance; the presence of trappings of the recovery culture enhances recovery initiation and maintenance.

---

401. Ward, J., Mattick, R.P., & Hall, W. (1998). How long is long enough? Answers to questions about the duration of methadone maintenance treatment. In J. Ward, R.P. Mattick, & W. Hall (Eds.), *Methadone maintenance treatment and other opioid replacement therapies* (pp. 305-336). Amsterdam: Harwood Academic.

402. Belding, M.A., McLellan, A.T., Zanis, D.A., & Incmikowski, R. (1998). Characterizing "nonresponsive" methadone patients. *Journal of Substance Abuse Treatment, 15*(6), 485-492.

403. MM patient feedback to authors, May 2010.

404. Goehl, L., Nunes, E., Quitkin, F., & Hilton, I. (1993). Social networks and methadone treatment outcome: The costs and benefits of social ties. *The American Journal of Drug and Alcohol Abuse, 19*(3), 251-262.

- There is a daily struggle for dominance between these two cultures within addiction treatment milieus.
- Relapse and recovery rates—good and bad—are as often influenced by the cultural milieu of treatment as by the intrapersonal factors of the patients.[405]

Treatment quality in MM has focused primarily on medication-related issues at the exclusion of the larger treatment milieu. As Dr. Edward Senay suggests,

> *… dispensing methadone is not synonymous with treatment. It is methadone plus an institutional or organization transference which is responsible for the success of methadone maintenance programs… The role of methadone is an important element in a whole, but it is a major error to confuse the element with the whole.*[406]

A distinctive dimension of recovery-oriented methadone maintenance (ROMM) is its emphasis on a therapeutic milieu that suppresses illicit drug cultures and provides a portal of entry into an alternative community of recovery. ROMM is distinguished by a:

- recovery-focused institutional identity, e.g., a recovery center that sees medication as an aid in the goal of recovery rather than defining itself institutionally as a methadone clinic;
- presence of recovery (hope, honesty, and mutual help) so palpable that it is socially contagious;
- physical plant that conveys respect via its safety, privacy, attractiveness, and comfort;
- distinctive recovery-focused culture reflected in language, literature, art, symbols, music, and daily rituals; and
- the visible presence of recovering people (e.g., recovering people serving as board members, staff, volunteers, and peer mentors) who offer living proof of the transformative power of long-term recovery.

THE LOCUS OF SERVICE DELIVERY

> *I haven't given a positive heroin urine in almost 20 years and I cannot go pick up a monthly prescription of my "medication." If I were psychotic and hearing voices and declared a schizophrenic, I WOULD be given a monthly prescription for powerful drugs and the freedom to pick up those drugs at a pharmacy. Yet I am not to be trusted because I am still viewed as a "junkie."*[407]

---

405. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

406. Senay, E.C. (1971). Methadone: Some myths and hypotheses. *Journal of Psychedelic Drugs*, *4*(2), 182-185.

407. MM patient email to authors, 2010

Treatment of acute illness most often involves placing a patient in a medical facility where he or she can be treated by a professional; the management of chronic illness focuses instead on nesting a recovery management process within each patient's natural environment. This distinction is important to the future of MM.

The focus of MM, like that of most addiction treatment modalities, has been on getting patients to the treatment facility (with methadone used in MM as the primary incentive for sustained patient-clinic contact). ROMM anticipates a greater focus on delivery of recovery support services outside the clinic and the greater integration of medication and other recovery support services within non-stigmatizing community environments. A possible omen of this shift is the vision of abolishing specialized MM clinics and integrating MM into organizations that are currently providing a comprehensive menu of treatment and recovery support services. Such a vision is now guiding the reorganization of addiction treatment in the State of New York.[408] We anticipate the evolution of OTPs from silo-like businesses toward integrated, recovery-oriented systems of care. We envision the expansion of medical maintenance in the United States (methadone and related recovery support services provided through a primary care physician) and the integration of medication and other recovery support services within other health and human service institutions within the community. The expansion of pre-treatment and post-treatment recovery support services will also create new home-based and neighborhood-based models of service delivery.

ROMM also is based on the concept of the community as patient—the idea that neighborhoods and whole communities can be severely wounded by addiction and be in need of community-level intervention and sustained recovery support. Also of import is the idea that recovery flourishes in supportive communities. ROMM seeks to shape community perceptions, attitudes, and actions that welcome and offer support and inclusion for people in long-term medication-assisted recovery. Long-term recovery outcomes are as often contingent upon community factors (e.g., attitudes toward methadone, methadone treatment, and methadone patients) as they are on intrapersonal factors.[409]

ASSERTIVE LINKAGE TO RECOVERY COMMUNITY RESOURCES

Peer-support has emerged as a primary recovery management strategy in the treatment of chronic illness. In the addiction context, there are two noteworthy trends. First, is the growth of peer recovery support via the ever-growing network of addiction recovery mutual aid groups, the

408. *OASAS Commissioner announces plans for one outpatient system of addiction services* [Press release]. (2009). State of New York Office of Alcoholism and Substance Abuse Services. Retrieved from http://www.oasas.state.ny.us/pio/press/pr-4-27-09methadone.cfm.

409. White, W. (2009c). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158.

philosophical (secular, spiritual, religious) diversification of these groups, the emergence of a new addiction recovery advocacy movement, new recovery community institutions (recovery homes, schools, industries, ministries, community centers), and the emergence of new peer-based service roles, e.g., that of the recovery coach.[410] Second is the growing body of scientific evidence that participation in peer-based recovery support societies and other recovery community institutions significantly elevates the prognosis for long-term recovery.[411] Community integration strategies may be particularly important for injection drug users, who often have prolonged histories of "institutional disaffiliation" and enmeshment in subterranean drug cultures.[412]

Methadone pioneers Drs. Vincent Dole and Marie Nyswander both had an interest in addiction recovery mutual aid societies. Dr. Nyswander served on the Board of Directors of the National Advisory Commission on Narcotics—the governing body of East Coast Narcotics Anonymous in the 1950s—and Dole served as a non-alcoholic trustee of Alcoholics Anonymous. Given this interest, one would think that mutual aid involvement would have been part of the original MM model. There are two likely reasons for its exclusion: 1) the fragile organizational status of NA at the time MM was being pioneered (there were only 4 NA meetings in New York City in 1965) and 2) the general antipathy toward "mainline addicts" in AA.[413]

The potential benefits of recovery mutual aid societies for patients in addiction treatment have not been fulfilled due to ineffective (passive) linkage procedures, ill-timed linkage (following rather than during treatment), failure to offer choices related to recovery support frameworks, and failure to match each patient to a person/meeting most likely to enhance the process of mutual identification and engagement.[414] The use of recovery mutual aid groups to enhance the recovery outcomes of MM patients has been further limited by:

- weak-to-nonexistent relationships between MM programs and local recovery mutual aid groups,
- the stigma attached to methadone (equation of methadone and heroin) within Narcotics Anonymous (e.g., common prohibitions against MM patients speaking at meetings, chairing meetings, chairing a service committee), which leads to avoidance of such groups or keeping one's MM status secret,[415]
- until the founding of Methadone Anonymous (1991), the lack of a recovery mutual aid society explicitly for people in medication-assisted recovery from heroin addiction,[416] and

410. White, W. (2008d). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

411. Kelly J.F., & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J.R. Cunningham (Eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

412. Lundgren, L.M., Schilling, R., Ferguson, F. Davis, K., & Amodeo, M. (2003). Examining drug treatment program entry of injection drug users: Human capital and institutional disaffiliation. *Evaluation and Program Planning, 26*, 123-132.

413. White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

414. White, W. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

415. Obuschowsky, M.A., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-step programs. *Journal of Psychoactive Drugs*, *19*(3), 301-302. White, W. (2009a). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/ recovery).* Philadelphia: Department of Behavioral Health and Mental Retardation Services. Zweben, J.E. (1987). Can the patient on medication be send to 12-step programs? *Journal of Psychoactive Drugs*, *19*(3), 299-300.

416. Gilman, S.M., Galanter, M., & Dermatis, H. (2001). Methadone Anonymous: A 12-step program for methadone maintained heroin addicts. *Substance Abuse*, *22*(4), 247-256. McGonagle, D. (1994). Methadone Anonymous: A 12-step program. Reducing the stigma of methadone use. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

- the lack of a model for peer-based recovery support services for patients in medication-assisted recovery, until the creation of the CSAT-funded Medication Assisted Recovery Services project in New York City in 2006.

ROMM has two long-term recovery support goals: 1) integrating people in medication-assisted recovery into existing communities of recovery and 2) building a recovery community and long-term recovery support services for people in medication-assisted recovery and their families.

> *I have participated in 12-Step type recovery programs and I find them a necessary part of treatment. It is a shame that NA and 12-Step groups feel about MMT patients like they do because I think if there was a way to combine the two therapies, there would be more successful recovering opiate addicts out there.*[417]

Promising practices within recovery-oriented methadone maintenance include active liaison between MM clinics and the service committees of local recovery mutual aid societies, encouraging/supporting the development of local Methadone Anonymous group meetings and other groups specifically for persons in medication-assisted recovery, assertive linkage of patients to the resources of local communities of recovery (including medication-friendly recovery support meetings), using volunteer or paid peer recovery coaches to facilitate patient connections to recovery community resources, coaching patients on how to address medication issues at recovery support meetings, hosting on-site peer recovery support meetings at MM clinics, sponsoring educational events on medication-assisted recovery for recovery community members, inclusion of indigenous healers and healing practices within MM clinics, using patient/alumni councils to visibly celebrate patient recovery milestones, and participating visibly in local recovery celebration events.[418] The key is to expose every patient entering MM to "living proof" of the reality and varieties/styles of long-term medication-assisted recovery.

POST-TREATMENT RECOVERY CHECKUPS, STAGE-APPROPRIATE RECOVERY EDUCATION AND SUPPORT, AND WHEN NEEDED, EARLY RE-INTERVENTION

Perhaps the most distinctive feature of chronic disease management is the prolonged if not lifelong duration of professional monitoring and support. In suggesting that addiction treatment should emulate this feature, Humphreys[419] referred to this as a shift in the focus in addiction treatment from one of *intensity* (high intensity acute stabilization) to one of *extensity* (low intensity but

417. Feedback from MM patient to authors, May 2010.

418. White, W., & Kurtz, E. (2006b). *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.

419. Humphreys, K. (2006). Closing remarks: Swimming to the horizon—reflections on a special series. *Addiction*, *101*, 1238-1240.

prolonged recovery support). The rationale for such assertive approaches to continuing care in the OTP context is worth restating. In spite of the theoretical potential of lifelong methadone maintenance, most patients cease MM treatment, often before they have reached the optimum time in MM. The therapeutic effects of MM erode for most patients following discharge from treatment.[420] Most patients who terminate MM resume opioid use/addiction—most within the first days and weeks of methadone cessation.[421] MM patients who leave treatment against medical advice or for program rule infractions are at particularly high risk for post-treatment relapse. Studies of long-term heroin addiction "careers" do not support the contention that persons chronically addicted to heroin eventually "mature out" of addiction as a function of aging; heroin addiction has the potential of being a lifelong condition.[422] The death rate for out-of-treatment methadone patients is 8-20 times that of in-treatment methadone patients.[423]

The recovery stability point (duration of current sobriety that predicts lifetime sobriety—the point at which the risk of future lifetime relapse drops below 15%) is higher for opioid addiction than for alcohol dependence—the latter being in the range of 3 to 5 years.[424] Five years' abstinence from heroin is a good benchmark for recovery stability,[425] but 14-25% of heroin addicts who achieve five or more years' abstinence will later return to opioid use.[426] Others addicted to heroin cease heroin use for extensive periods but fail to achieve this 5-year stability benchmark.[427] As we noted earlier, most people addicted to opioids experience prolonged addiction careers marked by cycles of treatment, periods of abstinence, relapse, and treatment re-entry.[428] Such data confirm the need for intense monitoring throughout early recovery and sustained if not lifelong recovery checkups combined with early re-intervention as needed for rapid restabilization.

Patients who have dropped out of MM and subsequently relapsed can be re-engaged through assertive models of outreach,[429] and patients who relapse following discharge from treatment show marked improvements following re-admission to treatment,[430] but the longer the delay in treatment re-entry, the more likely it is that such improvements will be compromised.[431] The level of improvement following re-entry to MM approximates that achieved during earlier treatment: as currently designed, there is no evidence of cumulative, progressive improvement across multiple episodes of MM treatment.[432] There is evidence that patients experiencing multiple MM treatment episodes stay in treatment longer in later episodes of treatment, creating opportunities for greater recovery stability.[433]

---

420. Greenfield, L., & Fountain, D. (2000). Influence of time in treatment and follow-up duration on methadone treatment outcomes. *Journal of Psychopathology and Behavioral Assessment*, *22*(4), 353-364.

421. Gossop, M., Green, L., Phillips, G., & Bradley, B. (1989). Lapse, relapse and survival among opiate addicts after treatment. *British Journal of Psychiatry*, *154*, 348-353.

422. Hser, Y. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51-60. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508.

423. Fugelstad, A., Stenbacka, M., Leifman, A., Nylander, M., & Thblin, I. (2007). Methadone maintenance treatment: The balance between life-saving treatment and fatal poisonings. *Addiction*, *102*, 406-412. Hser, Y. (2002). Drug use careers: Recovery and mortality. In Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Substance use by older adults: Estimates of future impact on the treatment system* (OAS Analytic Series #A-21, DHHS Publication No. (SMA) 03-3763, pp. 39-59). Rockville, MD: Substance Abuse and Mental Health Services Administration. Perkins, M.E., & Bloch, H.I. (1971). A study of some failures in methadone treatment. *American Journal of Psychiatry*, *128*, 47-51. Zanis, D.A., & Woody, G.E. (1998). One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence, 52*(3), 257-260.

424. 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.

425. Cushman, P., & Dole, V.P. (1973). Detoxification of rehabilitated methadone-maintained patients. *Journal of the American Medical Association, 226*(7). 747-752.

426. 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. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508. Simpson, D.D., Joe, G.W., Lehman, W.E.K., & Sells, S.B. (1986). Addiction careers: Etiology, treatment and 12-year follow-up outcomes. *Journal of Drug Issues*, *16*, 107-121. Simpson, D.D., & Marsh, K.L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F.M. Tims & C.G. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Research Monograph 72, DHHS Publication No. 88-1473, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

427. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508.

Studies of persons in long-term recovery from heroin addiction and persons who are continuing their heroin addiction careers confirm that negative affect and lack of coping skills are major risk factors for relapse and that self efficacy, social support, and participation in pro-social activities serve as the major protective factors for sustaining recovery.[434] Recovery checkups and other assertive approaches to continuing care following addiction treatment elevate short- and long-term recovery outcomes,[435] but systematic, long-term monitoring and support of patients who have ceased MM treatment are not common practices within OTPs.

Findings such as the above on the post-discharge status of methadone patients led Dr. Edward Senay[436] to recommend 25 years ago that all MM patients should have continued professional treatment for at least a year after tapering to a zero dose of methadone. The percentage of MM patients who receive such support is not even routinely measured in OTPs, but the authors suspect that percentage would be quite low. We envision a future in which a system of recovery check-ups; peer-based recovery support; stage-appropriate recovery education; assertive linkage to communities of recovery; and, when needed, early re-intervention will be standard practices in OTPs and that such practices will reduce post-treatment mortality and enhance the long-term recovery outcomes of MM patients. We would suggest as a beginning point for design of such services that MM patients be provided periodic recovery checkups for at least five years following achievement of a zero dose and/or any disengagement from treatment, with the frequency of contact determined by time (high intensity through the first 90 days of disengagement) and a personalized schedule of contact reflecting patient-identified circumstances in the future that are likely to pose elevated risks of drug use.

RECOVERY-ORIENTED METHADONE MAINTENANCE: FURTHER REFLECTIONS ON OUTCOME MEASURES

Methadone maintenance treatment has been evaluated using two broad benchmarks: 1) changes in behaviors that generate harm and costs to society (e.g., crime, disease transmission, unemployment, abuse/neglect/abandonment of children), and (as in the evaluation of other treatment modalities) 2) the percentage of clients who maintain abstinence or no longer meet diagnostic criteria for opioid dependence following discharge from treatment.

The first benchmark reflects legitimate public health concerns, although it is noteworthy that these have been collected and emphasized at the exclusion of measures of the effects of MM on

428. Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(3), 1-16. Lundgren, L.M., Sullivan, L., & Amodeo, M. (2006). How do repeaters use the drug treatment system? An analysis of injection drug users in Massachusetts. *Journal of Substance Abuse Treatment*, *30*, 121-128.

429. Zanis, D.A., McLellan, A.T., Alterman, A.I., & Cnaan, R.A. (1996). Efficacy of enhanced outreach counseling to reenroll high-risk drug users 1 year after discharge from treatment. *American Journal of Psychiatry*, *153*, 1095-1096.

430. Weisner, C., Ray, G.T., Mertens, J.R., Satre, D.D., & Moore, C. (2003). Short-term alcohol and drug treatment outcomes predict long-term outcome. *Drug and Alcohol Dependence*, *71*, 281-294.

431. Simpson, D.D., & Savage, L.J. (1980). Treatment re-entry and outcomes of opioid addicts during a four-year follow-up after drug abuse treatment in the United States. *Bulletin on Narcotics*, *32*(4), 1-10.

432. Powers, K.I., & Anglin, M.D. (1993). Cumulative versus stabilizing effects of methadone maintenance: A quasi-experimental study using longitudinal self-report data. *Evaluation Review*, *17*, 243-270.

433. Nosyk, B., MacNab, Y.C., Sun, H., Fischer, B., Marsh, D., Schecter, M.T., & Anis, A. (2009). Proportional hazards frailty models for recurrent methadone maintenance treatment. *American Journal of Epidemiology*, *170*(6), 783-792.

434. Hser, Y. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. *Journal of Addictive Diseases, 26*(1), 51-60.

435. 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. McKay, J. (2009). *Treating substance use disorders with adaptive continuing care*. Washington, D.C.: American Psychological Association. Scott, C.K., Dennis, M.L., & Foss, M.A. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, *78*, 325-338.

436. Senay, E.C. (1985). Methadone maintenance treatment. *International Journal of the Addictions*, *20*(6&7), 803-821.

personal/family recovery (including measures of global health and quality of life). As a professional field, we know a great deal about what methadone maintenance treatment can eliminate from the lives of patients, but we know very little from the standpoint of science about what it adds. In fact, we know very little about the stages and styles of long-term medication-assisted recovery. It is regrettable that information on long-term MM-assisted recovery has not been collected and used to shape a menu of stage-specific recovery support services.

Historically, multiple stakeholders other than MM patients have sat at the tables at which the criteria for evaluating MM have been defined. It is time MM patients and their family members are seated at these tables. There are thousands of stabilized MM patients in the United States who are invisible and silent. It is time they and their families were empowered to tell their recovery stories and help us as addiction professionals extract lessons from those stories that can elevate the quality of MM treatment and recovery support services.

The second benchmark, evaluating MM based on abstinence from all opioids following cessation of MM, is a fundamentally flawed approach. Dr. Robert Newman[437] explains:

> *… the assessment of methadone's effectiveness in the treatment of addicts continues to focus on the study of former patients who are no longer receiving treatment—a focus no more logical than gauging the effectiveness of birth-control pills by counting the number of pregnancies that occur after administration is discontinued…Methadone is dismissed by many and damned by others because it does not "cure" patients or render them immune from such societal ills as unemployment, alcoholism, marijuana smoking, and criminality. In other words, methadone maintenance has come to be evaluated by virtually every criterion except a decline in heroin use.*

Evaluating MM on in-treatment and post-treatment abstinence from alcohol and non-opioid drugs is similarly flawed if OTPs are not designed and funded to provide services beyond methadone pharmacotherapy that are capable of treating co-occurring drug dependencies.

We propose that OTPs and all other addiction treatment programs be evaluated based on the same criteria and that such criteria be drawn from the Betty Ford Institute Consensus Panel definition of recovery—a definition that through its core components of sobriety, global health, and citizenship encompasses personal, family, and community interests. Using these criteria might

437. Newman, R.G. (1987). Methadone treatment: Defining and evaluating success. *New England Journal of Medicine*, *317*, 447-450.

lead to enriching MM with a much broader array of professional and peer-based recovery support services and extend such support to patients far beyond the potential cessation of methadone pharmacotherapy. The same criteria would focus attention on intermediate outcome measures (related to sobriety, global health, and community reintegration) and process measures (attraction, access, engagement, retention, service duration, etc.) that have a strong nexus to long-term personal and family recovery outcomes. Such an approach is consistent with McLellan and colleagues'[438] call to shift the evaluation of addiction treatment from a model of evaluating discrete episodes via post-treatment follow-up to a process of *concurrent recovery monitoring* and evaluating unique combinations and sequences of service elements on long-term addiction, treatment, and recovery careers.[439]

A BRIEF NOTE ON EVIDENCE-BASED PRACTICES IN ROMM

We have tried to the extent possible to ground our recommendations in this article within the peer-reviewed scientific literature, but it is important to acknowledge that every MM program sees patients whose needs are never reflected in the randomized clinical trials that the field so worships. These are the patients who present with multiple drug choices, multiple co-occurring disorders, and multiple personal and environmental obstacles to long-term recovery. These patients are the first to be excluded from clinical trials and the first to be extruded from mainstream OTPs. We know almost nothing about the prevalence, pathways, and styles of long-term recovery for such patients or the kinds of clinical and support interventions that help facilitate such recoveries. Lacking such a scientific roadmap, we would be well served to find ways to listen to these patients and their families and forge models of care that respond to the complexity of their needs. We cannot assume that what we have learned about the treatment of MM patients in clinical trials applies to those patients with more complex needs. Of all patients entering OTPs today, these are the patients most in need of the kind of long-term recovery partnership we have described in this article.[440]

SUMMARY

This article has outlined a vision of recovery-oriented methadone maintenance (ROMM). Put simply, ROMM seeks to:

- *focus on recovery from addiction* rather than remission of a drug-specific disorder (e.g., opioid dependence);

438. McLellan, A.T., McKay, J.R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction*, *100*, 447-458.

439. White, W. (2008c). *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.

440. Senay, E. (2010). Personal communication, February 16, 2010.

- *attract* people at an earlier stage of addiction via programs of assertive community education, screening, and outreach;
- *ensure rapid service* access for individuals and families seeking help;
- *resolve obstacles* to admission, initial stabilization, and continued participation in MM treatment;
- *achieve safe, optimum dose stabilization* through individualized patient care that is responsive to patients' needs and respectful of patients' preferences and values;
- *engage and retain* individuals and families in a recovery-focused service relationship marked by mutual respect, hope, and emotional authenticity;
- *assess* patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;
- *transition* each patient from a professionally directed treatment plan to a patient-directed recovery plan;
- *shift the service relationship* from a professional expert model to a long-term recovery partnership/consultation model;
- *ensure minimum (at least one year of stabilization) and optimum (individualized) duration of treatment* via focused retention strategies, assertive responses to early signs of disengagement, and use of patient surveys to identify and resolve grievances that might contribute to disengagement;
- *shift the treatment focus* from that of an episode of care to the management of long-term addiction/treatment/recovery careers;
- *ensure that MM patients are afforded educational and counseling services* on a par with those offered to patients in other addiction treatment modalities.
- *expand the service menu* to include medical/psychiatric/social services, non-clinical, peer-based recovery support services, and spiritual and culturally indigenous healing activities;
- *extend the locus of service delivery* beyond the OTP clinic to non-stigmatized service sites and neighborhood-based, church-based, work-based, and home-based recovery support services;

- *assertively link patients/families* to recovery community support resources (including 12-Step groups, other recovery mutual aid societies, and grassroots recovery advocacy and support organizations), and identify and establish partnerships with non-traditional sources of patient support within the community (e.g., faith-based recovery ministries);
- *engage the community* via a positive program presence in the community, anti-stigma and community education campaigns about medication-assisted recovery, and recovery community development activities;
- *provide individualized plans for post-treatment monitoring and support, stage-appropriate education, support, and early re-intervention* for all patients regardless of discharge status; and
- *evaluate MM treatment* using proximal and distal indicators of long-term personal and family recovery.

Achieving these changes in practice will be contingent on re-aligning the philosophy of MM toward a greater focus on long-term personal and family recovery (as opposed to a narrower focus on reduction of social harm), and it will require re-aligning the context of MM (policy, regulatory, funding, and community environment) to support this recovery vision. Facilitating such a transformation will in turn require enhancing the organization infrastructures of OTPs in such critical areas as capitalization, leadership/workforce development and stabilization, technological capabilities, institution-community relationships, and advocacy capabilities. As discussions proceed on the potential for OTP systems transformation, care should be taken to explore the risks of unintended consequences within such a transformation process.[441] We will need to address critical questions, including:

- Is there a risk that opioid-addicted persons not desirous of recovery as defined in this monograph will be punished, denied services or otherwise abandoned for their lack of readiness to accept this goal? Might new recovery rhetoric be used to justify punitive treatment of "recovery-resistant" patients?
- Could approaches to recovery-oriented methadone maintenance be used to foist services on patients who do not need or want or cannot afford such services?
- Might this recovery orientation add a new layer of regulatory demands on OTPs that in the long run will add administrative burdens and further depersonalize service relationships?

441. A special thanks to Dr. Robert Newman for raising this concern.

Might these new recovery-focused regulatory demands actually decrease the individualization of care within the OTP? (Our fear here is of new mandates for particular types of services for *all* patients.)

- Is there not a danger that the assertive outreach programs advocated in this monograph might quickly overwhelm national OTP capacities?
- What effects will increased patient retention have on community treatment capacity?
- Will the financial resources required to deliver a service-enriched model of methadone maintenance reduce the numbers of people served by the OTPs and inadvertently widen the gap between treatment needs and treatment capacity?
- Might the emphasis on patient-directed recovery plans and peer-based recovery support services inadvertently lead to the deprofessionalization of addiction treatment?
- Are there circumstances in which patients might be harmed within the context of peer-based recovery support services? What kinds of screening, selection, training, supervision practices and ethical guidelines will be needed to minimize this risk?
- Might the integration of medication-assisted treatment and recovery support services into health, human services, and other community organizations lead to the eventual destruction of OTPs and the broader addictions field as a specialized arena of care?
- Will the resources that will be required to provide sustained continuing care following cessation of MM reduce OTP capacity for acute stabilization and maintenance?

We feel that the best way of avoiding such risks is to ensure that one particular voice is always at the table and prominent in the coming discussions of recovery-oriented methadone maintenance. For the past 45 years, the design of methadone maintenance treatment in the United States has rested in the hands of policy-makers, scientists, and treatment professionals. The voice of the patient in shaping MM has grown from a whisper to the early stirrings of a patient advocacy movement. In preparing this monograph, we talked with many MM patients, including a particularly hidden population of MM patients: those who have achieved prolonged recovery, health, productivity, and service. What we found through these latter conversations is a population of current and former MM patients who are strong, capable, and willing and ready to participate and help lead such systems-transformation processes. They represent an unknown portion of MM patients in

the U.S., and they have achieved a high quality of life in recovery, sometimes in spite of treatment milieus in which recovery was rarely discussed.

> *I think it is WAY past time for MMT patients to speak up and stop allowing those who do not have a clue to make the rules and regs for methadone treatment. I am tired of the clinics taking advantage of patients and treating us like they do, and I will do whatever is needed to help change these things.*[442]

Many MM patients will not become excited about a heightened recovery orientation of their clinic until they are first engaged in education and discussion about recovery—what recovery means in the MM context, pathways and styles of recovery, its prevalence, and its rewards. Perhaps the greatest failure of methadone maintenance is represented in the high proportion of MM patients who understand methadone maintenance as a *treatment* for opioid addiction but lack an understanding of medication-assisted long-term recovery. OTPs will have come of age when their emphasis shifts from the personal and social injuries that MM subtracts from patients' lives to a focus on what recovery-oriented methadone maintenance can add to the quality of personal, family, and community lives.

Patients will embrace a vision of recovery only to the extent that the realities of their daily lives and their needs and aspirations are reflected in that vision. Patients thus need to be co-creators of the vision rather than just passive recipients. That vision will most easily flow from the collective experiences of current and former MM patients whose quality of personal and family life has been elevated through their recovery journeys. We believe that the visioning process needs to start with conversations between patients who have survived the demands of the clinic system and have built lives of sustained recovery, and patients who are beginning treatment, often with little understanding of, or hope for, long-term recovery. We think the recovery vision we speak of can emerge from such connections.

The seeds for a vibrant MM patient advocacy and peer support movement have been sown for decades by individual patients and early advocacy efforts.[443] The time for the full emergence of that movement has arrived, and as it comes of age, this movement will profoundly shape the future of medication-assisted treatment and recovery in the United States. One of the most significant challenges to be faced is the social and professional stigma attached to medication-assisted treatment and recovery, particularly methadone-assisted treatment and recovery. That will be the subject of the final article in this monograph.

---

442. MM patient feedback to authors, May 2010.

443. Woods, J. (2001). Methadone advocacy: The voice of the patient. *The Mount Sinai Journal of Medicine*, *68*, 75-78.

IV: Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Philadelphia

William L. White, MA

> *The guiding vision of our work must be to create a city and 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."*[444]

INTRODUCTION

When Dr. Arthur Evans, Jr. assumed leadership of the Philadelphia Department of Behavioral Health and Mental Retardation Services in 2004, he initiated a broad community-visioning exercise that ignited a "recovery-focused systems transformation" process. Systems transformation involves aligning concepts, contexts (policies, regulatory guidelines, funding mechanisms), and service practices to: 1) identify and engage individuals and families affected by alcohol and other drug (AOD) problems, 2) help these individuals and families initiate and sustain a process of long-term recovery, and 3) enhance the quality of personal/family life in long-term recovery. The emerging vision in Philadelphia was to create a city and 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."[445]

The purpose of this article is twofold. First, it provides an overview of key findings drawn from historical and scientific research on social/professional stigma related to addiction to illicit drugs, with a particular focus on the stigma experienced by people in medication-assisted treatment and long-term medication-assisted recovery. Second, it outlines a menu of potential strategies that could be implemented by the Philadelphia Department of Behavioral Health and Mental Retardation Services and its many community partners to reduce this stigma. The document was prepared with input

444. Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma*. Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

445. Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *National Recovery Month helps reduce stigma*. Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

from local and national addiction treatment professionals and recovery advocates and is intended as a starting point for further discussions and strategy-development meetings that will be facilitated by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

STIGMA BASICS

Stigma Defined

Stigma is the experience of being "deeply discredited" due to one's "undesired differentness." To be stigmatized is to be held in contempt, shunned, or rendered socially invisible because of a socially disapproved status.[446] It involves processes of labeling, stereotyping, social rejection, exclusion, and extrusion—the essential ingredients of discrimination.[447]

There are three types of personal stigma:

- Enacted stigma (direct experience of social ostracism and discrimination)
- Perceived stigma (perception of stigmatized attitudes held by others toward oneself)
- Self-stigma (personal feelings of shame and self-loathing related to regret over misdeeds and "lost time" in one's life due to addiction).[448]

Self-stigma, or internalized stigma, results from the internalization of community attitudes by the person being discredited.

Stigma and Addiction

There is an extensive body of literature documenting the stigma attached to alcohol and other drug problems.[449] No physical or psychiatric condition is more often or more deeply associated with social disapproval and discrimination than alcohol and/or other drug dependence.[450] The social stigma attached to addiction constitutes a major obstacle to personal and family recovery, contributes to the marginalization of addiction professionals and their organizations, and limits the type and magnitude of cultural resources allocated to alcohol- and other drug-related problems.[451]

Stigma and Recovery

Addiction-related social stigma extends to people who have achieved stable recovery from addiction.[452] In fact, people in recovery may have a greater fear of stigma and experience stigma more intensely precisely because of their recovery status and all that they now have to lose.[453] The

446. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Englewood Cliffs: Prentice-Hall.

447. Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health*, *7*, 331-343. van Olphen, J., Eliason, M.J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention and Policy, 4*. Retrieved from http://www.substanceabusepolicy.com/content/pdf/1747-597X-4-10.pdf.

448. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

449. Dean, J.C., & Rud, F. (1984). The drug addict and the stigma of addiction. *International Journal of Addictions, 19*(8), 859-869. McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283-288. Sobell, L.C., Sobell, M.B., & Toneatto, T. (1992). Recovery from alcohol problems without treatment. In N. Heather, W.R. Miller, & J. Greeley (Eds), *Self control and addictive behaviors* (pp. 198-242). New York: Maxwell Macmillian.

450. Corrigan, P.W., Watson, A.C., & Miller, F. E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20*(2), 239-246.

451. Woll, P. (2005). *Healing the stigma of addiction: A guide for treatment professionals.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

452. Tootle, D.M. (1987). Social acceptance of the recovering alcoholic in the workplace: A research note. *Journal of Drug Issues*, *17*, 273-279.

453. Woods, J. (2009). Personal communication, July 27, 2009.

intensity of stigma varies by problem intensity and different styles of recovery. Stigma attached to natural recovery may be less severe, due to the perception of it as more noble (pulling oneself up by the bootstraps) and to the possibility that people might perceive the naturally recovering person as having had less severe problems. At the same time, natural recovery is often viewed by the public as less credible and durable than recovery from severe AOD problems initiated through professional treatment.[454]

Courtesy Stigma

The social stigma attached to addiction can be experienced by families, organizations (e.g., addiction treatment programs), neighborhoods, and whole communities.[455] Goffman[456] referred to this stigma-by-association as "courtesy stigma."[457]

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 inciting or failing to prevent relapse episodes. Children may be socially shunned due to the perception that they have been contaminated by the addiction of their parents or siblings.[458]

Many family member behaviors that historically have been defined as "enabling" or "co-dependent" are better understood as attempts to protect the family from the stain of social stigma.[459] The "courtesy stigma" experienced by family members as embarrassment and shame is often displaced on the family member experiencing AOD problems in the form of anger and exclusion. Family members thus sacrifice their own family member to escape or lessen their own social condemnation.

Addiction-related courtesy stigma can also extend to particular organizations, neighborhoods, and communities. Professionals who work with stigmatized groups may also be affected by this same stigma through, for example, the stigma's effects on addiction professionals' percption of themselves in relation to other fields and disciplines, and on the ways in which they are perceived by others. A particular neighborhood can be stigmatized when AOD problems become part of its public identity through repeated portrayal of the neighborhood's challenges with no references to its strengths. Examples of ways in which whole communities can be stigmatized by addiction-related stigma include the historical portrayal of the surge in cocaine use in the late 19th and early 20th centuries, and again in the 1980s, as a distinctly African American problem[460] and the centuries-long misrepresentation ("firewater myths") of the nature of alcohol problems in Native American communities.[461]

---

454. Cunningham, J.A., Sobell, L.C., & Chow, V.M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol, 54*(6), 693-699.

455. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346.

456. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice-Hall.

457. Also see: Barton, J.A. (1991). Parental adaptation to adolescent drug abuse: An ethnographic study of role formulation in response to courtesy stigma. *Public Health Nursing, 8*(1), 39-45.

458. Corrigan, P.W., Watson, A.C., & Miller, F.E. (2006). Blame, shame and contamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20*(2), 239-246.

459. *The stigma of substance abuse: A review of the literature.* (1999). Toronto, Canada: Centre for Addiction and Mental Health.

460. White, W., & Sanders, M. (2002). Addiction and recovery among African Americans before 1900. *Counselor, 3*(6), 64-66.

461. Coyhis, D. & White, W. (2006). Alcohol problems in Native America: The untold story of resistance and recovery—The truth about the lie. Colorado Springs, CO: White Bison, Inc.

Stigma and Choice

Addiction has been alternately defined as a problem of vulnerability (an involuntary medical/psychiatric disease) and a problem of culpability (a voluntary, self-inflicted moral lapse/character defect/vice/habit). The former model provides pathways of return to health; the latter proscribes sequestration and punishment as blame for moral/criminal liability, as a means of rehabilitation, and/or as a method of suppressing excessive substance use in the community.[462] Stigma rises for some but not all disorders in which the individual is perceived as having personally contributed to the onset of the disorder. People with substance use disorders are less likely to be offered help by other citizens than are people with mental illnesses or physical disabilities.[463] The stigma attached to drug dependence, and arguments for and against the personal or social harm or value of such stigma, hinge to a great degree on widely varying views on the degree to which those with significant alcohol and other drug problems have voluntary control over their drug use.

Stigma and Motivation for Drug Use

American attitudes toward addiction have varied based on the motivation for drug use, with relief of pain viewed as more excusable than the search for unearned pleasure.[464] Where pain-related addiction elicits compassion, addiction that results from the search for pleasure elicits condemnation and social marginalization. At the same time, cultural phobia related to opioid addiction and fear that addiction-related stigma will be attached to prescription opioid use has resulted in the underuse of opioid medication in the treatment of acute and chronic pain, from both physician hesitation to prescribe opioids and patient ambivalence about taking opioid medications.[465] Perhaps the best example of this is patients' resistance to their physicians' suggestions that they take methadone for chronic pain because of the patients' association with methadone as "that junkie drug." This is further exacerbated by public and professional confusion on the difference between *physical dependence* on an opioid medication and opioid *addiction* (See later discussion).

Stigma and "Badness"

American social policies on licit and illicit drugs have long been bifurcated by the notion of *good drugs* and *bad drugs*, with drugs in the latter category rated across degrees of badness. Good drugs have been celebrated, commercialized, and taxed as a source of government revenue with control mechanisms relying primarily on the social and legal definitions of who can use, when use can occur, where use can occur, how much can be consumed, and under what conditions use

---

462. 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. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

463. Corrigan, P.W., Kuwabara, S.A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work, 9*(2), 139-147.

464. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

465. Woods, J. (2009). Personal communication, July 27, 2009.

can and cannot occur. Bad drugs (and their users) have been demonized and prohibited, with the space between good and bad occupied by tolerated drugs (discouraged but not prohibited, e.g., tobacco) and instrumental drugs (approved for use only under special circumstances, e.g., prescription drugs). Historically, heroin and crack cocaine have been the most severely stigmatized substances and injection drug use the most severely stigmatized method of ingestion.[466] The manner in which stigma triggered by public panic can demonize users and suppress treatment seeking is well illustrated by the "moral panic" linked to crack cocaine in the 1980s and the more recent panic related to surges in methamphetamine use.[467] The attribution of "badness" (social stigma) has for most of the past century been most intense for those persons who regularly self-inject heroin.[468]

By extension, greater addiction recovery-related stigma is extended to people in opioid treatment modalities. This 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.[469] In one of the most recent studies of methadone-related stigma, 98% of MAT patients surveyed reported that "stigma is an essential feature of methadone maintenance treatment."[470] For many opiate addicts, the stigma attached to medication-assisted treatment (MAT) is internalized from the culture at large and from illicit opioid street cultures long before treatment becomes a possibility or a necessity. Members of the illicit opioid street culture are also aware of methadone-related stigma and discrimination—spanning employment, child custody, access to other forms of addiction treatment, and even denial of certain privileges within the recovery community, e.g., right to speak at a recovery fellowship meeting, chair a meeting, head a service committee, or be credited with "clean time" while taking methadone.[471]

Multidimensional Stigma

The weight of addiction-related social stigma is not equally applied. Its burdens fall heaviest on those with the fewest 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, aging) and when these conditions are perceived as conflicting with gender-linked role responsibilities, e.g., those of addicted pregnant women/mothers.[472] Persons experiencing such layered, multidimensional stigma are less likely to seek addiction treatment than persons experiencing a single discredited condition.[473] The social stigma attached to addiction begins primarily at the point

466. Capitanio, J.P., & Herek, G.M. (1999). AIDS-related stigma and attitudes toward injecting drug users among Black and White Americans. *American Behavioral Scientist*, *42*(7), 1144-1157. Jones, E.E., Farina, A., Hastorf, A.H., Markus, H., Miller, D.T., Scott, R.A., et al. (1984). *Social stigma: The psychology of marked relationships*. New York: W.H. Freedman. Surlis, S., & Hyde, A. (2001). HIV-positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, *12*, 68-77.

467. Semple, S.J., Grant, L., & Patterson, T.L. (2005). Utilization of drug treatment programs by methamphetamine users: The role of social stigma. *The American Journal of Addictions*, *14*, 367-380. Humphries, D. (1999). *Crack mothers: Pregnancy, drug and the media*. Columbus: Ohio University Press.

468. Surlis, S., & Hyde, A. (2001). HIV-positive patients' experiences of stigma during hospitalization. *Journal of the Association of Nurses in AIDS Care*, *12*, 68-77.

469. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264. Woods, J. (2001). Methadone advocacy: The voice of the patient. *The Mount Sinai Journal of Medicine*, *68*, 75-78.

470. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

471. Hettema, J., & Sorenson, J.L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*. Online publication ahead of print. Retrieved from http://www.springerlink.com/content/c5v56125880u2p64/. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine, 67*, 347-364.

472. Anderson, T.L., & Levy, J.A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction, 98*, 761-770. Capitanio, J.P., & Herek, G.M. (1999). AIDS-related stigma and attitudes toward injecting drug users among Black and White Americans. *American Behavioral Scientist*, *42*(7), 1144-1157. Conner, K.O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions, 8*(2), 244-264. Minior, T., Galea, S., Stuber, J., Ahern, J., & Ompad, D. (2003). For the patient. Does discrimination affect the mental health of substance abusers? *Ethnicity and Disease, 13*(4), 549-550. Yannessa, J.F., Reece, M., & Basta, T.B. (2008). HIV provider perspectives: The impact of stigma on substance abusers living with HIV in a rural area of the United States. *AIDS Patient Care, 22*(8), 669-675.

473. Conner, K.O., & Rosen, D. (2008). "You're nothing but a junkie": Multiple experiences of stigma in an aging methadone maintenance population. *Journal of Social Work Practice in the Addictions, 8*(2), 244-264.

of admission to treatment (a social signal of problem severity) and intensifies with multiple treatment episodes (a social signal of treatment failure).[474] One MAT patient distinguished the "inner shame" experienced during active addiction from the "public shame when you're in the clinic."[475]

Stigma in the Professional Context

The majority of health care professionals hold negative, stereotyped views of illicit drug users. These views are shaped for the most part, not by their professional training, but by each professional's past experimentation with or lack of experimentation with illicit drugs.[476]

Stigma, Treatment-Seeking, and Long-Term Health

Stigma can elicit social isolation, reduce help-seeking, and compromise long-term physical and mental health status.[477] Social stigma is a major factor in preventing individuals from seeking and completing addiction treatment[478] and from utilizing harm-reduction services such as needle exchange programs.[479] Social stigma increases the service needs of persons with substance use disorders, but, by fostering social rejection and discrimination, that same stigma decreases access to such services.[480] Treatment seeking is also reduced by the perception that drug treatment program staff will "treat you like a little, nasty dope fiend."[481]

Chronic Illness, Stigma, and Methadone Maintenance

Acute illness is something you have ("I have a cold"); chronic illness is something you are ("I am a diabetic"). With acute illnesses, one experiences the onset of the illness, one is professionally treated or self-treated, and one recovers without a lasting imprint on personal or social identity. Chronic illness bears a greater stigma burden, in part because of the uncertainty with which the concept of recovery is applicable to a condition that is prolonged; is not in a technical sense "cured"; and will require sustained self-management and, in many cases, periodic professional treatment. Chronic illness can inflict social death, a loss of self, and a struggle to define a "time horizon" for recovery.[482]

Vigilant[483] attributes the stigma attached to methadone maintenance to the imperfect medicalization of chronic opioid addiction and its treatment. By "imperfect," Vigilant means that: 1) heroin addiction and its treatment have been trapped between medical and moral/criminal models of problem definition and resolution; 2) methadone maintenance has never achieved full legitimacy as a medical treatment in the eyes of the public, health care professionals, and the recovery

474. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346.

475. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

476. McLaughlin, D., & Long, A. (1996). An extended literature review of health professionals' perceptions of illicit drugs and their clients who use them. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 283-288.

477. Ahern, J., Stuber, J., & Galea, S. (2007). Stigma, discrimination and the health of illicit drug users. *Drug and Alcohol Dependence, 88*(2-3), 188-196. Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*, 177-190. Minior, T., Galea, S., Stuber, J., Ahern, J., & Ompad, D. (2003). For the patient. Does discrimination affect the mental health of substance abusers? *Ethnicity and Disease, 13*(4), 549-550.

478. Luoma, J.B., Twohig, M.P., Waltz, T., Hayes, S.C., Roget, N., Padilla, M., et al. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors, 32*(7), 1331-1346. Thom, B. (1986). Sex differences in help-seeking for alcohol problems—I. The barriers to help-seeking. *The British Journal of Addictions*, *81*, 777-788.

479. Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy, 20*(2), 121-130.

480. van Olphen, J., Eliason, M.J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment Prevention and Policy, 4*. Retrieved from http://www.substanceabusepolicy.com/content/pdf/1747-597X-4-10.pdf.

481. Beschner, G.M. & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J. M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

482. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.* Vigilant, L. G. (2008). "I am still suffering:" The dilemma of multiple recoveries in the lives of methadone patients. *Sociological Spectrum, 28*, 278-298. Vigilant, L.G. (2005). "I don't have another run left with it": Ontological security in illness narratives of recovery on methadone maintenance. *Deviant Behavior, 26*(5), 399-416.

483. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses.*

community, in spite of the scientific studies supporting it; 3) the person enrolled in methadone maintenance has never received full status as a "patient"; and 4) the methadone clinic has yet to be viewed as a place of healing on a par with hospitals or outpatient medical clinics.

Vigilant further argues that heroin addicts entering methadone treatment are christened "patients," but the treatment protocol—required daily clinic visits, forced sequestration of addicts together in a closed group regardless of recovery motivation and status, restrictive and inflexible medication pickup schedules, public exposure while standing in line for medication, observed urination for drug testing, mandatory counseling, sanctions for violations of treatment rules—is more akin to the status of "inmates" of "total institutions" than protocol befitting a medical patient.[484] Methadone clinics have not achieved the social status of medical clinics because they have not been allowed to operate like medical clinics. Methadone patients have not achieved their full status as "patients" because they have not been treated as patients.

The "Catch-22" in which the methadone patient, methadone treatment staff, and methadone clinic as an institution are trapped grew out of the conflicting interests that emerged as methadone maintenance was mainstreamed as a treatment modality. On the one hand, there were the needs of the methadone patient and the need for a long-term service relationship based on empathy, trust, and respect. On the other hand, there were concerns about public safety via the potential for methadone diversion. This tension between a milieu of engagement and empowerment and a milieu of distrust and control left those being served caught between the status of a patient and the status of a prisoner/probationer, and left physicians/nurses/counselors caught between their aspirations to serve as healers and onerous, regulatory-imposed policing functions.[485] The result is a demedicalized system in which people entering methadone maintenance are treated more like criminals (or recalcitrant children) than patients, within a relational world more dominated by surveillance and control than compassion and choice.[486]

> *… clients often felt that the relationship between themselves and their counselors was less focused on therapy than power; less about psychological growth, getting help, and a sense of well-being than about social control, conforming to rules and regulations, and punishment.*[487]

Such focus on control rather than care may be even more greatly exaggerated for female patients,

---

484. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses*.

485. Best, D. (2009). Personal communication.

486. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149.

487. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J. A. Inciardi, & L. D. Harrison (Eds.), *Heroin in the age of crack-cocaine*. Thousand Oaks, CA: Sage.

leaving unattended many obstacles to participation and recovery, e.g., child care, transportation, caretaking responsibilities, sabotage from addicted partners, threats of partner violence, and difficulty paying for treatment.[488]

The professional status of methadone treatment has suffered from the absence of theoretical models of addiction treatment and recovery that integrate the prevailing preoccupation with the mechanics of the medicine (e.g., concern with dosages, pick-up schedules, drug testing, take-home privileges, tapering procedures) and control of the milieu (e.g., concern with loitering) with a focus on the broader physical, cognitive, emotional, relational, occupational, and spiritual aspects of long-term recovery.[489] The lack of such theoretical models and the performance expectations emanating from such models breeds clinics in which patients' contact with their counselors is rare, brief, and superficial, and in which ancillary services are minimal. As a result, methadone patients are all too often rendered and perceived as "passive figures onto which a treatment modality [methadone] is applied."[490] Missing is the image of the methadone patient as his or her own engineer of an enduring process of global (whole life) recovery.

Types of Stigma Attached to Methadone Maintenance

Vigilant's[491] study of the phenomenology of methadone-assisted recovery revealed five types of stigma unique to methadone treatment:

1. **Methadone treatment stigma:** the stigma attached to treatment for opiate addiction; methadone treatment as a social signal of problem severity; stigma attached to methadone as a treatment modality by the culture at large and by major segments of the professional and recovery communities. (Methadone-related stigma is far greater for women than men, due to the perceived connection between heroin addiction and prostitution).
2. **Dose stigma:** the stigma attached within the clinic culture to those on high doses of methadone—a status often interpreted by other patients as indicating a lack of interest in recovery.
3. **Stigma of personal regret:** shame of looking back on the devastation to self, family, and community caused by heroin addiction.
4. **Stigma-related loss of associational ties:** shrinking of the social network to the recovery/clinic community, in order to avoid the social stigma attached to addiction and methadone treatment.

---

488. Fraser, J. (1997). Methadone clinic culture: The everyday realities of female methadone clients. *Qualitative Health Research*, *7*(1), 121-139.

489. Hagman, G. (1995). A psychoanalyst in methadonia. *Journal of Substance Abuse Treatment, 12*(3), 167-179.

490. Hunt, G., & Rosenbaum, M. (1998). 'Hustling' within the clinic: Consumer perspectives on methadone maintenance treatment. In J.A. Inciardi, & L.D. Harrison (Eds.), *Heroin in the age of crack-cocaine*. Thousand Oaks, CA: Sage.

491. Vigilant, L.G. (2001). "Liquid handcuffs": The phenomenology of recovering on methadone maintenance. *Boston College Dissertations and Theses*.

5. **Loss-of-control stigma:** shame related to the excessive demands of the clinic, its domination of one's life and forced participation in shaming rituals (e.g., observed urination to confirm that urine for drug testing is "fresh" and not being surreptitiously substituted).

Dr. Robert Newman[492] places Viglant's work within an important historical perspective. Newman argues that the original model of methadone maintenance was corrupted as it was mainstreamed.[493] Methadone treatment during this transition phase shifted to lower methadone doses, shorter lengths of methadone treatment participation, and decreased emphasis on services for collateral problems (e.g., counseling, employment, housing) that are critical to recovery stabilization and maintenance. These changes violated the original theoretical framework of methadone maintenance to the extent that Newman drew the following provocative conclusion:

> *Methadone maintenance treatment, with its unique, proven record of both effectiveness and safety, no longer exists. One can only hope that it is not too late to reassess that which has been cast aside, and to resurrect a form of treatment which has helped so many, and which could help many more.*[494]

Payte[495] suggests that the history of methadone maintenance treatment stands as an argument for professional activism:

> *It is no longer sufficient to take care of patients. Treatment providers must also become teachers, public relations workers, politicians, and advocates for all patients who want and need treatment.*[496]

Personal Responses to Stigma

There is a high degree of variability in the ways in which persons in methadone maintenance respond to stigma. Patients with more positive self-concepts and more social resources are better able to counter stigma and assert the positive benefits of MAT. Those with lower self-esteem and fewer social resources are less capable of resisting stigma and tend to self-define methadone treatment as another addiction (internalized stigma).[497] Personal strategies to deal with stigma include:

- Secrecy/concealment (e.g., concealing one's methadone treatment status at AA and NA meetings)
- Social withdrawal (e.g., avoiding new friendships, avoiding recovery support meetings)

---

492. Newman, RG. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186. See also: Des Jarlais, D.C., Paone, D., Friedman, S.R., Peyset, N. & Newman, R.G. (1995). Regulating controversial programs for unpopular people: Methadone maintenance and syringe exchange programs. American Journal of Public Health, 85(11), 1577-84.

493. See Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

494. Newman, RG. (1976). Methadone maintenance: It ain't what it used to be. *British Journal of Addiction, 71*, 183-186.

495. Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107.

496. Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs, 23*(2), 103-107. See also Newman,, R.G., & Peyser, N. (1991). Methadone treatment: Experiment and experience. *Journal of Psychoactive Drugs, 23*(2), 115-121.

497. Gourlay, J., Ricciardelli, L., & Ridge, D. (2005). Users' experiences of heroin and methadone treatment. *Substance Use and Misuse, 40*(12), 1875-1882.

- Preventive disclosure (selective disclosure to test acceptability)
- 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)
- Political activism.[498]

People with diminished internal assets and diminished social capital experience difficulty resisting a stigmatizing label and challenging the personal/organizational entities that are applying the label.[499]

Stigma and Cultures of Addiction

Social stigma contributes to the propensity of persons with drug dependencies to become enmeshed in illicit drug subcultures.[500] 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.[501] 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 having less control of their drug use.[502] Such attitudes can be played out within the social pecking order of drug treatment milieus. "Street cultures" are also embedded with myths designed to inhibit treatment-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement, including a number of myths about methadone (e.g., "it rots your teeth and bones").[503]

Many individuals enmeshed in such cultures progressively diminish their contact with the mainstream culture and become as dependent on the culture of addiction as they have been on the drugs in their lives. As drug-related personal impairment escalates, individuals may experience rejection and isolation from both the mainstream society and the illicit drug cultures that have sheltered them.[504] If recovery and community reintegration are to be achieved and sustained, addiction treatment, recovery mutual aid societies, and other helping structures must facilitate a journey from the culture of addiction, or from this marginalized isolation, to a culture of recovery. Stigma is a major obstacle to successfully traversing the physical, psychological, and social space between these two worlds.[505] Methadone advocate Walter Ginter recently reflected on this journey:

---

498. Herman, N. (1993). Return to sender: Reintegrative stigma-management strategies for ex-psychiatric patients. *Journal of Contemporary Ethnography*, *22*(3), 302-321. Link, B.G., Struening, E.L., Rahav, M., Phelan, J.C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior*, *38*, 177-190. Shih, M. (2004). Positive stigma: Examining resilience and empowerment in overcoming stigma. *Annals of the American Academy of Political and Social Science*, *591*, 175-185. Vigilant, L.G. (2004). The stigma paradox in methadone maintenance: Naïve and positive consequences of a "treatment punishment" approach to opiate addiction. *Humanity and Society, 28*(4), 403-418.

499. Schur, E.M. (1971). *Labeling deviant behavior: Its sociological implications*. New York: Harper & Row Publications.

500. Anderson, T.L. (1993). Types of identity transformation in drug using and recovery careers. *Sociological Focus*, *26*(2), 133-145. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden. Anderson, T.L., & Ripullo, F. (1996). Social setting, stigma management, and recovering drug addicts. *Humanity and Society, 20*, 25-43.

501. Agar, M. (1977). *Ripping and running: A formal ethnography of urban heroin addicts*. New York: Seminar Press, Inc. Biernacki, P. (1979). Junkiework, hustles, and social status among heroin addicts. *Journal of Drug Issues*, *9*, 535-551. Finestone, H. (1969). Cats, kicks and color. In H. Becker (Ed.), *The other side* (pp. 281-297). New York: Free Press. Waldorf, D. (1973). *Careers in dope.* Englewood Cliffs, NJ: Prentice-Hall, Inc. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

502. Boeri, M.W. (2004). "Hell, I'm an addict but I ain't no junkie": An ethnographic analysis of aging heroin users. *Human Organization*, *63*, 236-245. Simmonds, L., & Coomber, R. (2009). Injecting drug users: A stigmatized and stigmatizing population. *International Journal of Drug Policy, 20*(2), 121-130. Sutter, A.G. (1966). The world of the righteous dope fiend. *Issues in criminology*, *2*, 177-222. Zinberg, N.E. (1984). *Drug, set, and setting: The basis for controlled intoxicant use*. New Haven: Yale University.

503. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

504. Anderson, T.L., & Levy, J.A. (2003). Marginality among older injectors in today's illicit drug culture: Assessing the impact of ageing. *Addiction*, *98,* 761-770.

505. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

> *Methadone patients are caught between these two cultures. Even if recovery is their goal, they must stand in line at the clinic each day with people who are as interested in the best crack spot as they are about recovery. Under such a handicap, it is amazing that many patients find their way to medication-assisted recovery. When they do, it is more likely to be in spite of the treatment system than because of it. We have to find a way to separate the culture of addiction from the culture of recovery in our OTP's [opioid treatment programs]. It is unreasonable to expect patients to find recovery until we do.*[506]

Ginter's observation elicits the image of "life in the queue"—the social influences that pervade interactions in the dosing line of the methadone clinic. The long-term addiction/recovery scales may well be tipped as much by the milieu as by methadone as a medication in the treatment of addiction.[507]

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.[508] One major strategy, seeking to inculcate the belief that alcohol and drug addiction is a disease, may help alleviate personal shame[509] but has not been consistently shown to produce sympathetic attitudes toward those with severe alcohol and other drug problems.[510] Public surveys reveal that those who agree that alcohol and drug addiction is a disease are more likely to see these problems as severe and intractable and to doubt reports of successful recovery.[511]

One of the most effective strategies to reduce social stigma is to increase interpersonal contact between mainstream citizens and members of the stigmatized group.[512] Contact between stigmatized and non-stigmatized groups as a vehicle of stigma reduction is most effective when the contact is between people of equal status (mutual identification); is personal, voluntary, and cooperative; and is mutually judged to be a positive experience.[513] Encounters marked by such characteristics break down in-group/out-group boundaries of "us" and "them."

Social stigma is influenced by social proximity and distance. For example, community attitudes toward Oxford Houses are most positive among neighbors who live closest to these houses.[514] Reducing social distance and increasing interpersonal contact are important goals of any anti-stigma campaign. Individuals can express negative feelings toward a particular group

---

506. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

507. Fraser, S., & Valentine, K. (2008). Substance and substitution: Methadone subjects in liberal societies. New York: Macmillan.

508. Corrigan, P.W., & Penn, D.L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*, 765-776.

509. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

510. Crawford, J.R., Thomson, N.A., Gullion, F.E., & Garthwaute, P. (1989). Does endorsement of the disease concept of alcoholism predict humanitarian attitudes to alcoholics? *The International Journal of the Addictions*, *24*, 71-77. Cunningham, J.A., Sobell, L.C., & Chow, V.M. (1993). What's in a label? The effects of substance types and labels on treatment considerations and stigma. *Journal of Studies on Alcohol, 54*(6), 693-699.

511. Cunningham, J.A., Sobell, L.C., & Sobell, M.B. (1996). Are disease and other conceptions of alcohol abuse related to beliefs about outcome and recovery? *Journal of Applied Social Psychology, 26*(9), 773-780.

512. Corrigan, P.W. (2002). Testing social cognitive models of mental illness stigma: The prairie state stigma studies. *Psychiatric Rehabilitation Skills*, *6*, 232-254. Corrigan, P.W., River, L.P., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion, J., et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, *27*, 187-195. Corrigan, P.W., & Wassel, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing and Mental Health Services*, *27*, 187-195. Couture, S.M., & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, *12*, 291-305.

513. Couture, S.M., & Penn, D.L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health*, *12*, 291-305.

514. Jason, L.A., Roberts, K., & Olson, B.D. (2005). Attitudes toward recovery homes and residents: Does proximity make a difference? *Journal of Community Psychology, 33*(5), 529-535.

while simultaneously having positive regard for individuals of that group. As such relationships increase, the sentiment toward the group weakens and dissipates. Strategies that focus on increasing public awareness of multiple pathways of long-term recovery and exposing people to others who have resolved these problems may be more effective in countering social stigma than promoting a particular conceptualization of the nature of addiction.[515]

HISTORICAL/SOCIOLOGICAL PERSPECTIVES

The social stigma attached to certain patterns of psychoactive drug use has a long history in the United States and is inseparable from cultural strain related to such issues as race, religion, social class, gender roles, and intergenerational conflict. The social reform campaigns that have demonized certain drugs and classes of drug users shared common conceptual themes:

- The drug is associated with a hated subgroup of the society or a foreign enemy.
- The drug is identified as solely responsible for many problems in the culture, e.g., crime, violence, insanity.
- The survival of the culture is pictured as being dependent on the prohibition of the drug.
- The concept of "controlled" use is destroyed and replaced by a "domino theory" of chemical progression.
- The drug is associated with the corruption of young children, particularly their sexual corruption.
- Both the user and the supplier of the drug are defined as fiends, always in search of new victims; use of the drug is considered "contagious."
- Policy options are presented only in terms of total prohibition or total access.
- Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated.[516]

These themes shape what Lindesmith[517] referred to as "dope fiend mythology"—a "body of superstition, half-truths and misinformation" that claims that narcotic drug use causes moral degeneracy and violent crime (rape and murder) and that drug "pushers" and drug users have a voracious appetite for infecting non-users.[518] Modern studies of the historical origins of these myths have placed their beginnings within the Federal Bureau of Narcotics' early and mid-twentieth-century

---

515. Corrigan, P.W. (2002). Testing social cognitive models of mental illness stigma: The prairie state stigma studies. *Psychiatric Rehabilitation Skills, 6*, 232-254. Cunningham, J. A., Sobell, L. C., & Sobell, M.B. (1996). Are disease and other conceptions of alcohol abuse related to beliefs about outcome and recovery? *Journal of Applied Social Psychology, 26*(9), 773-780.

516. White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

517. Lindesmith, A.R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

518. It was Lindesmith's position that moral degeneracy was a consequence of drug policy rather than drug pharmacology: "If our addicts appear to be moral degenerates and thieves it is we who have made them that by the methods we have chosen to apply to their problems." Lindesmith, A. R. (1940). Dope fiend mythology. *Journal of Criminal Law, Criminology and Police Science*, *31*, 199-208.

anti-drug campaigns,[519] but similar myths were also promulgated by the leaders of nineteenth-century anti-alcohol, anti-tobacco, anti-opium, and anti-cocaine campaigns.[520] These myths about the nature of various drugs and the nature of the drug user constitute the conceptual foundation of addiction-related stigma.

The social stigma attached to methadone is rooted in a larger anti-medication bias within the history of addiction treatment.

That bias is rooted in the fact that many new drugs announced as breakthroughs in the treatment of alcohol and other addiction were later found to create problems in their own right. Alcohol, opium, morphine, cocaine, cannabis, barbiturate and non-barbiturate sedatives, amphetamines and other psychostimulants, LSD, and the so-called "minor" tranquilizers have all been claimed to have curative properties in the treatment of addiction.[521] The history of such iatrogenic insults bodes caution and close scientific scrutiny of any new drug claimed as a treatment for drug addiction.[522] But that same history also suggests that newly developed drugs of unsurpassed effectiveness might be socially and professionally rejected because of this traditional anti-medication bias.

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.[523] These campaigns have generated policies of isolation, control, and punishment of drug users.[524] 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."[525] 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.[526] 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 reduce addiction-related stigma must engage multiple community groups in ways that alter community perception of the sources and solutions to alcohol and other drug problems.

---

519. Reasons, C.E. (1972). *Dope, fiends and myths*. Paper presented at American Sociological Association's Annual Meeting (New Orleans, LA, August). Reasons, C.E. (1976). Images of crime and the criminal: The dope fiend mythology. *Journal of Research in Crime and Delinquency, 13*(2), 133-144.

520. White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

521. White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

522. White, W.L. & Kleber, H.D. (2008). Preventing harm in the name of help: A guide for addiction professionals, *Counselor*, *9*(6), 10-17.

523. Jonnes, J. (1996). *Hep-cats, narcs, and pipe dreams*. New York: Scribner. Musto, D. (1973). *The American disease: Origins of narcotic controls*, New Haven: Yale University Press.

524. White, W. (1979). Themes in chemical prohibition. In *Drugs in perspective*. Rockville, MD: National Drug Abuse Center/National Institute on Drug Abuse.

525. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

526. There are those who take an extreme position on this, arguing that addiction is a moral problem, addicts are "bad people," stigma attached to addiction is good and should be increased, the internalized stigma attached to addiction directs most addict violence within the drug culture, and that any lowering of that stigma might create a re-direction of that violence outward toward normal citizens. Dalrymple, T. (2007). *Junk Medicine: Doctors, lies and the addiction bureaucracy*. Great Britain: Harriman House, Ltd.

Efforts to increase or reduce stigma attached to illicit drug use may have intended or unintended side-effects.[527]

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 efforts may also promote patterns of social exclusion and discrimination within local communities that block the ability of drug-dependent individuals to reenter mainstream community life. Second, community education efforts aimed at reducing stigma might increase drug use.[528] This might occur if these campaigns inadvertently normalized illicit drug use, increased non-user curiosity about drug effects, conveyed the impressions that addiction treatment is an assured safety net (available and affordable) or that recovery is easily attainable, or 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 two related questions: 1) "What is the source of stigma?" and "Who profits from stigma?"[529]

Efforts by one group to define another group as deviant can serve psychological, political, and economic interests. Simply put, stigmatizing others often serves to increase the self-esteem of the stigmatizer.[530] 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, a campaign that defines a particular group as "outsiders" serves to confirm one's own status as an "insider." 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.

---

527. Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155.

528. Gerber, J. (1973). Role of the ex-addict in drug abuse intervention. *Drug Forum*, *2*(2), 105-106.

529. Weinstein, 2009, personal communication.

530. Tajfel, H., & Turner, J.C. (1979). An integrative theory of intergroup conflict. In W.G. Austin, & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-48). Monterey, CA: Brooks/Cole.

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, changes in community attitudes have in the past 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 a manipulation of public opinion by hidden financial interests, e.g., developers who would profit from gentrification of a neighborhood targeted for a new addiction treatment facility.[531]

Formal studies of public resistance to locating behavioral health (addiction or mental health) treatment clinics and recovery homes in a particular neighborhood have drawn several key conclusions. Facilities that notify neighbors before their entrance into the community experience greater initial resistance than those who do not, but achieve better long-term relationships with the local community—particularly when the facility has an active strategy of neighborhood relations, e.g., open houses and community service.[532] Many facilities are well accepted in their communities, and acceptance is associated with public concepts of "social responsibility and collective care."[533] Acceptance is highest among community residents who are younger, are more economically and educationally advantaged, personally know someone in recovery, rely on education/experience rather than the media as the most important source of information, see facility residents as similar to other people, and believe local residents encountering behavioral health problems should have access to local, community-based services.[534] By enhancing positive recovery outcomes, larger facilities (eight or more residents) generate fewer neighborhood complaints related to criminal or aggressive behavior.[535]

Local opposition to the opening of a new methadone clinic has been linked to fear of increased drug use and crime, fear of potential effects on property values, objections to the profits made by private methadone clinics, and philosophical opposition to methadone as a treatment and as a perceived method of social control of communities of color.[536] This opposition can be reduced by involvement of neighborhood leaders in site planning, placement of clinics in low-traffic areas, minimization of patient visibility (e.g., providing space for socializing to minimize loitering outside

531. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

532. Zippay AL. (2007). Psychiatric Residences: Notification, NIMBY, and Neighborhood Relations. *Psychiatric Services* 58, 109–113. http://www.psychservices.psychiatryonline.org/

533. Zippay, A. & Lee, S.K. (2008). Neighbors' perceptions of community-based psychiatric housing. *Social Service Review* 82(3), 395-417.

534. Iutcovich, M., Iutcovich, J., & Strikland, W .J. (1996). Group homes for the mentally ill? NIMBY! *Social Insight*, 11-15. Repper, J., & Brooker, C. (1996). Public attitudes toward mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

535. Jason, L.A., Groh, D.R., Durocher, M., Alvarez, J., Aase, D.M., & Ferrari, J.R. (2008). Counteracting "Not in My Backyard": The positive effects of greater occupancy within mutual-help recovery homes. *Journal of Community Psychology, 36,* 947-958.

536. Genevie, L., Struening, E.L., KAllos, J.E., Gelier, I., Muhlin, G.L. & Kaplan, S. (1988). Urban community reaction to health facilities in residential areas: Lessons from the placement of methadone facilities in New York City. *The International Journal of the Addictions*, *23*(6), 603-616.

the clinic, encouraging early morning pickups), and demonstration that methadone clinic patients can make a positive contribution to the community (e.g., community service programs).[537]

There has been considerable rethinking of the NIMBY issue. First, NIMBY may represent, not local prejudice, but a local manifestation of a belief system that is deeply ingrained within the national culture—suggesting the need for national as well as local anti-stigma strategies.[538]

> *It is essential that attempts are made to improve tolerance not only within local populations but also within the total population. This might be achieved through a broad based educational and awareness raising strategy which is properly funded by purchasers of health and social care.*[539]

Second, as a local issue, NIMBY is being viewed as more than a manifestation of misinformation and prejudice.

> *Siting conflicts should not be seen as resulting from the unreasonable and selfish attitudes of the local population, but as a real reflection of concerns about health, safety, quality of life, political interests, rights and moral issues… There is a need to break out of adversarial approaches toward cooperation.*[540]

Siting conflicts may be minimized if preceded by efforts to promote community consensus on such key propositions as the following:

- Each family/neighborhood has a responsibility to take care of its own.
- Each neighborhood/community is responsible for developing a level of prevention, early intervention, treatment, and recovery support services commensurate with the vulnerability to AOD problems in that neighborhood.
- Neighborhoods/communities may band together to create a full continuum of prevention, early intervention, treatment, and recovery support services available to all of their members, with all neighborhoods/communities having a voice (through their elected representatives) regarding the location of such resources.
- Neighborhoods/communities have a right to be involved in planning decisions related to the siting of new addiction treatment and recovery support resources.

---

537. Genevie, L., Struening, E.L., KAllos, J.E., Gelier, I., Muhlin, G.L. & Kaplan, S. (1988). Urban community reaction to health facilities in residential areas: Lessons from the placement of methadone facilities in New York City. *The International Journal of the Addictions, 23*(6), 603-616.

538. Tempalski, B., Friedman, R., Keem, M., Coopoer, H. & Friedman, S.R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States, Geoforum, 38(6), 1250-1263.

539. Repper, J., & Brooker, C. (1996). Public attitudes toward mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

540. Repper, J., & Brooker, C. (1996). Public attitudes toward mental health facilities in the community. *Health and Social Care in the Community*, *4*(5), 290-299.

- Neighborhoods/communities have a right to know the extent to which individuals served by a treatment or recovery support facility come from within or outside the neighborhood/community.
- Neighborhoods/communities have a right to know about potential problems that may arise within treatment and recovery support facilities and how such problems will be managed.
- Organizations seeking to open new treatment or recovery support facilities have a right to a fair hearing in which they can present ways in which that facility meets current legal/regulatory requirements and ways in which the facility will benefit the community via services, jobs, and economic resources.[541]

The stigma attached to methadone treatment for opioid addiction is rooted in the unique history of this drug and its close association with heroin addiction.

Methadone maintenance as a treatment for heroin addiction has grown from a handful of patients in the mid-1960s to more than 260,000 patients in 2008 (plus an additional 140,000 opioid-dependent patients being treated with buprenorphine).[542] Early attacks on methadone in the late 1960s and 1970s focused on what was perceived as "drug substitution" and concerns about methadone diversion and methadone-related deaths.[543] Since that time, attitudes toward methadone are due in great part to the fact that the least stabilized medication-assisted treatment (MAT) patients and the worst MAT programs (e.g., poorest clinical, administrative, and fiscal practices) garner nearly all of the attention the media gives to the subject of methadone treatment.

Widely disseminated myths and misconceptions about the drug methadone and methadone maintenance as an addiction treatment have flourished since its introduction and continue to affect discussions about methadone at personal, professional, public, and policy levels. In spite of the established scientific legitimacy and effectiveness of methadone maintenance treatment (see later citations), methadone patients are forced to hide their "dirty little secret" for fear of social rejection and discrimination.[544]

Attitudes toward methadone as a mechanism of recovery support are unique in the broad arena of addiction treatment. For other areas of recovery support (e.g., participation in professional continuing care groups, peer-based recovery support meetings, daily recovery support rituals not involving medication), there is consistent praise for continuing or increasing these activities over

---

541. White, W. (2009). Personal Communication to Dr. Arthur Evans

542. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305.

543. Kleber, H. (2008). Methadone maintenance 4 decades later: Thousands of lives saved but still controversial. *Journal of the American Medical Association*, *300*(9), 2303-2305.

544. Gryczynski, J. (2005). *Patient views on methadone treatment as conveyed in an online support group.* Presented at the annual meeting of the American Sociological Association, Philadelphia, PA. Murphy, S., & Irwin, J. (1992). "Living with the dirty secret": Problems of disclosure for methadone maintenance clients. *Journal of Psychoactive Drugs, 24*(3), 257-264.

time. But for the person whose recovery is supported by methadone, there is encouragement to taper off methadone and congratulations when such tapering is complete, in spite of research finding high relapse rates following such tapering and the lack of expectation among patients or staff that tapering will be successful.[545] Professional congratulations to the person who similarly reduced and ended his or her recovery support meeting participation would be unthinkable in most current recovery cultures.[546]

The stigma attached to methadone is also shaped by the expectations of methadone treatment as a system of care. Methadone advocate Walter Ginter comments on such expectations:

> *Patients, former patients, staff, policy makers, and the public expect the methadone treatment program to treat* ***addiction****. While that is a reasonable expectation, it is not what Opioid Treatment Programs (OTPs) do. OTPs treat opiate* ***dependence****, and they do it very well. Most patients on an adequate dose of methadone do not continue to use opiates. However, opiate addiction is more than dependence on opiates; it is dependence combined with a series of behaviors. OTPs (with a few exceptions) do not treat the behavioral aspects of addiction. The behavioral aspects are not treated by a medication but rather by counseling, therapy, peer recovery supports, and 12-step groups. As long as well-intentioned people go around saying that* ***"methadone is recovery,"*** *it is going to continue to be misunderstood. Methadone is a medication, a tool, even a pathway, but it is not recovery. Recovery is a way of living one's life. It doesn't come in a bottle.*[547]

Modern OTPs, under the influence of the American Association for the Treatment of Opioid Dependence, are making significant strides in moving from this narrow focus on metabolic stabilization to the broader processes involved in addiction treatment and long-term addiction recovery.[548]

Patients entering methadone treatment are as likely to be seeking respite as they are to be seeking recovery.[549] Entrance into addiction treatment can be a milestone in one's addiction career as well as a potential milestone of recovery.[550] It is the milieu of the clinic, the service relationships, and the broader menu of services in which methadone is nested that can tip the scales from the former to the latter. The social and professional perception of methadone treatment as consisting almost exclusively of the medication itself has contributed to the stigma attached to methadone and methadone maintenance treatment.

---

545. Gold, M. L., Sorenson, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment*, *5*, 37-44.

546. Woods, J. (2009). Personal communication, July 27, 2009.

547. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

548. Kaltenbach, K. (2009). Personal Communication, October 12, 2009.

549. Faulpel. C. (1999). *Shooting dope*. Gainesville, FL: University of Florida Press. Johnson, P. D., & Friedman, J. (1993). Social versus physiological motives in the drug careers of methadone clinic clients. *Deviant Behavior: An Interdisciplinary Journal, 14*, 23-42.

550. White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City: Hazelden.

CONCEPTUAL UNDERPINNINGS OF MAT-LINKED STIGMA

Social and professional stigma, particularly stigma associated with methadone treatment, is buttressed by a set of core assumptions or beliefs. Table 1 (beginning on the following page) outlines some of these key assumptions and beliefs and their current scientific status.

Table 1: Stigma-Linked Beliefs and Their Scientific Status

STIGMA-LINKED BELIEFS	THE SCIENCE
1. Compulsive drug use is a choice, and such voluntary choices and their consequences should not be masked within a disease rhetoric that fails to hold people accountable for their decisions and actions.	1. Volitional control over whether to use or not use a drug, and how much and for how long to use once use begins, progressively diminishes in vulnerable populations as the brain is "hijacked" via the dysregulation of normal brain functioning produced by sustained drug exposure.[551]
2. Methadone is a "crutch": it provides symptomatic treatment but fails to treat the deeper emotional and relational disturbances that led to the initiation and maintenance of heroin addiction.[552]	2. Opioid addiction is at its core more a physiological than psychological disorder,[553] but recovery rates in MAT can be compromised by high rates of co-occurring medical and psychiatric disorders.[554] MAT outcomes are enhanced when methadone is wrapped in a broader menu of medical, psychiatric, and social services.[555] The primary rationale for MAT is the following: the physiological core of opioid dependence requires a core treatment of physiological stabilization; abstinence-based treatment of opioid dependence is limited in terms of attraction, retention, and post-treatment outcomes because it lacks this core physiological treatment.

551. Dackis, C., & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience*, *8*(11), 1431-1436. Shaham, Y., & Hope, B. T. (2005). The role of neuroadaptations in relapse to drug seeking. *Nature Neuroscience*, *8*(11), 1437-1439.

552. Beschner, G.M., & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J.M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

553. Kreek, M.J., & Reisinger, M. (1997). In J. Lowinson, P. Ruiz, R.B. Millman, & J.G. Langrod (Eds.), *Substance abuse: A comprehensive text* (pp. 822-853). Baltimore, MD: Williams and Wilkins.

554. Cacciola, J.S., Alterman, A.I., Rutherford, M.J., McKay, J.R., & Milvaney, F.D. (2001). *Drug and Alcohol Dependence*, *61*, 271-280.

555. Abbot, P.J., Moore, B., Delaney, H., & Weller, S. (1999). Retrospective analyses of additional services for methadone maintenance patients. *Journal of Substance Abuse Treatment*, *17*(1-2), 129-137. Hesse, M., & Pedersen, M.U. (2008). Easy-access services in low-threshold opiate agonist maintenance. *International Journal of Mental Health and Addiction*, *6*(3), 316-324. McLellan, A. T., Arndt, I.O., Metzger, D.S., Woody, G.E., & O'Brien, C.P. (1993). The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association*, *269*, 1953-1959.

STIGMA-LINKED BELIEFS	THE SCIENCE
3. Methadone simply replaces one drug/addiction for another: "methadone is like the alcoholic replacing Bourbon with Scotch."[556]	3. Injected heroin produces intense euphoria, whereas oral consumption of appropriate doses of methadone in an opioid-tolerant patient produces a normalizing rather than a euphoric effect.[557] Because of this, most patients on methadone view methadone as a "medication" rather than a "drug."[558] Methadone and buprenorphine are best thought of as addiction-ameliorating medications rather than addiction-inducing drugs.[559] Methadone, like other legal medications, is subjected to quality controls (assurance of proper and consistent dosage and purity) not available with illicit opioids. Self-reports of MMT patients switching from being a "slave to heroin" to a "slave to methadone"[560] have more to do with the rigorous demands of the MMT clinic structure than with the pharmacological equivalency of heroin and methadone.
4. Methadone maintenance diminishes one's capacity to eventually achieve long-term abstinence from opiates.	4. The effect of methadone on the duration of addiction careers is unclear. Maddux and Desmond[561] found rates of long-term abstinence (defined in this study as abstinence from all opiates including methadone) of persons following MMT (9-21%) similar to those for persons treated in drug-free treatment (10-19%). The data "do not suggest that methadone impedes eventual recovery."[562] In a study published the same year, Maddux and Desmond conducted a 10-year follow-up comparison of patients with less than one year and more than one year on methadone maintenance and concluded: "methadone maintenance for 1 year or longer impedes eventual recovery from opioid dependence." They went on to say that "For many patients, however, the benefits of prolonged methadone maintenance could outweigh the possible cost of diminished likelihood of eventual recovery."[563] A definitive answer to the effects of methadone maintenance on long-term addiction and recovery careers remains unclear. Future studies must include those in stable medication-assisted treatment without secondary drug use, with indicators of progress toward global health and community integration within the definition of recovery.[564]

556. Marion, I.J. (2009). Personal communication with author, June 24, 2009.

557. Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

558. McGonagle, D. (1994). Methadone Anonymous: A 12-Step program. *Journal of Psychosocial Nursing*, *32*(10), 5-12.

559. Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems*, *8*(4), 5-8.

560. Baldino, R.G. (2000). *Welcome to Methadonia: A social worker's candid account of life in a methadone clinic*. Harrisburg, PA: White Hat Communications.

561. Maddux, J.F., & Desmond, D. P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74.

562. Maddux, J.F., & Desmond, D. P. (1992). Methadone maintenance and recovery from opioid dependence. *American Journal of Drug and Alcohol Abuse*, *18*(1), 63-74.

563. Maddux, J.F. & Desmond, D.P. (1992). Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, *18*(3), 289-303.

564. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

STIGMA-LINKED BELIEFS	THE SCIENCE
5. Low doses and short periods of methadone maintenance result in better rates of long-term recovery.	5. There is a significant relationship between methadone dosage and the odds of continued heroin use during MAT.[565] Two-thirds of methadone treatment patients receive inadequate daily dosages of methadone-dosages below 80 mg/day[566]—in spite of growing evidence that higher dosages are linked to greater reductions in the use of other opiates, greater reductions in secondary drug use (e.g. cocaine, benzodiazepines),and enhancements in global recovery outcomes.[567] The effective duration of methadone maintenance associated with the best long-term recovery outcomes is at least one year of participation.[568] In 2002, the average length of time from admission to discharge in outpatient methadone maintenance was 175 days.[569]
6. MAT patients should be encouraged to end MAT as soon as possible.	6. The majority of opioid-dependent persons leaving MAT, like their opioid-dependent counterparts leaving drug-free treatment, quickly relapse, and up to two-thirds later return to treatment—often for repeated episodes of treatment.[570] The choice to end MAT is a decision to be made by the patient in consultation with his or her physician, but it is best attempted after a substantial period of stability in MAT and with increased support during and following the tapering and cessation periods. The inability of some people to successfully taper from methadone may result more from physiological differences than from inadequate levels of personal motivation or family/social support.

SEMANTIC AND VISUAL IMAGES UNDERPINNING MAT-RELATED STIGMA

Social and professional stigma attached to opiate addiction and medication-assisted treatment (MAT) is buttressed by language. It is manifested in language that demedicalizes the status of addiction and depersonalizes and demonizes those with the disorder. Words and phrases such as *drug habit, drug abuse, dope fiend, junkie, smackhead, addict, dirty* (versus clean), *user, client* (rather than *patient*), and *substitution* all reflect such demedicalized and objectifying language.[571]

565. Caplehorn, J.R.M., Bell, J., Kleinbaum, D.G., & Gebski, V.J. (1993). Methadone dose and heroin use during maintenance treatment. *Addiction*, *88*, 119-124. Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2001). Outcomes after methadone maintenance and methadone reduction treatments: Two-year follow-up results from the National Treatment Outcome Research Study. *Drug and Alcohol Dependence, 62*(3), 255-264.

566. D'Aunno, T. (2006). The role of organization and management in substance abuse treatment: Review and roadmap. *Journal of Substance Abuse Treatment*, *31*, 221-233.

567. Gerra, G., Ferri, M., Polidori, E., Santoro, G., Zaimovic, A., & Sternieri, E. (2003). Long-term methadone maintenance effectiveness: Psychosocial and pharmacological variables. *Journal of Substance Abuse Treatment*, *25*, 1-8.

568. Simpson, D.D., & Joe, G.W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, *27*, 99-121.

569. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005). *Treatment Episode Data Set (TEDS): 2002. Discharges from Substance Abuse Treatment Services* (DASIS Series: S-25, DHHS Publication No. (SMA) 04-3967). Rockville, MD. Retrieved from http://wwwdasis.samhsa.gov/teds02/2002_teds_rpt_d.pdf.

570. Ball, J.C., & Ross, A. (1991). *The effectiveness of methadone maintenance treatment: Patients, programs, services and outcomes*. New York: Springer Verlag. Bell, J., Burrell, T., Indig, D., & Gilmour, S. (2006). Cycling in and out of treatment; participation in methadone treatment in NSW, 1990-2002. *Drug and Alcohol Dependence*, *81*, 55-61.

571. White, W. (2001). *The rhetoric of recovery advocacy.* Retrieved from www.facesandvoicesofrecovery.org. NAMA (1994). Client vs. patient. National Alliance of Methadone Advocates, inc, Policy Statement # 4, May, 1994. Retrieved July 28, 2009 from http://www.methadone.org/nama-documents/ps04client_v_patient.html.

> *… these terms [substitution therapy, replacement therapy] do not confer legitimacy or status on treatment… indeed the opposite is the case. All are associated with a culture of inauthenticity, and as a result, their value is permanently in question. It might be that, endemic as this language of substitution has become, new terms should be found.*[572]

The stigma attached to heroin addiction has been extended to methadone treatment and intensified through such language as *methodonia, methodonian*, and *deathadone*. Books with titles like *Methadone: A Technological Fix*[573] are popular, and the titles of professional articles proclaim "Stoned on Methadone," "Hooked: The Madness in Methadone Treatment," "Methadone: The Forlorn Hope," and "The Methdonians." Film "documentaries" are promoted through such titles as "Methadonia," and "Methadone: An American Way of Dealing,"[574] and methadone treatment is commonly portrayed as ineffective through such popular films as "Sid and Nancy," "Trainspotting," and "Permanent Midnight."[575] The language of methadone maintenance (e.g., its designation as a "substitution therapy" or "replacement therapy") has contributed to the stigma attached to MAT by reinforcing the proposition that MAT is nothing more than the replacement of an illegal high with a legal high.[576]

As noted earlier, the social stigma attached to narcotic addiction has been internalized within American drug cultures. The pecking orders within these cultures are reinforced by one's status as a *righteous dope fiend, hope-to-die dope fiend,* or *gutter hype*. Such pecking orders can be acted out within the addiction treatment milieu as well as within local drug cultures.

STREET MYTHS AND STIGMA

Stigma attached to methadone has also been infused within the illicit drug culture of the United States.[577] Beginning on the following page, Table 2 illustrates some of the methadone-related myths that pervade the American drug culture and that serve to inhibit treatment-seeking behavior and contribute to early treatment termination.

572. Fraser, S., & Valentine, K. (2008). *Substance and substitution: Methadone subjects in liberal societies.* New York: Macmillan.

573. *Nelkin*, D. (*1973*). Methadone *maintenance: A technological fix.* New York: George Braziller.

574. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition.* Unpublished doctoral dissertation, City University of New York.

575. Cape, G.S. (2003). Addiction, stigma, and movies. *Acta Psychiatrica Scandinavica, 107*(3), 163-169.

576. Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems, 8*(4), 5-8.

577. Beschner, G.M., & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J.M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

Table 2: Myths and Facts

THE MYTH	THE FACTS
1. The name Dolophine (a pharmaceutical brand of methadone marketed by Eli Lilly) was named for Adolf Hitler.	1. The "dolo" in Dolophine comes from the Latin dolor, meaning "pain," and the "phine" likely comes from morphine or is derived from "fin," meaning "end"; the name reflects the search for an alternative for morphine in the treatment of pain.[578]
2. Methadone is addicting.	2. Prolonged use of methadone, like that of any opioid, induces physical dependence, but there is no evidence that it induces addiction. The definitional determinants of addiction have historically included three components: 1) tolerance, 2) withdrawal, and 3) compulsive use in spite of adverse consequences. Methadone meets the first two criteria, but not the third. Since its widespread introduction, there has not been a significant population of people who compulsively pursue methadone as a primary drug choice, although the potential for emergence of such a population continues to be monitored.[579] People maintained on methadone for prolonged periods may be physically dependent upon methadone, but their addiction is to heroin or other short-acting narcotics, not methadone.
3. Methadone is harder to "kick" than heroin.	3. Acute withdrawal from methadone takes longer than acute withdrawal from heroin.
4. Methadone is nothing more than a cheap, legal high for people who cannot obtain heroin.	4. Methadone at optimal doses does not produce intoxication; it produces physiological stabilization without heroin's brief cycles of withdrawal distress and impairment related to acute intoxication.
5. Once on methadone, you can never get off of it.	5. Relapse rates are high following cessation of both heroin and methadone. Some individuals do initiate and maintain recovery with the aid of methadone and later stop using methadone as a recovery adjunct while maintaining successful long-term recovery.

578. Payte, J.T. (1991). A brief history of methadone in the treatment of opiate dependence: A personal perspective. *Journal of Psychoactive Drugs*, *23*(2), 103-107.

579. A few commentators suggested that this has recently begun to change and that trends in this area should be closely monitored.

THE MYTH	THE FACTS
6. Methadone maintenance extends the total length of addiction careers.	6. There is no scientific evidence that MAT lengthens addiction careers; addiction careers are instead influenced by factors such as age of onset of use, degree of problem severity/complexity, and the level of personal recovery capital (internal and external resources that can be mobilized to initiate and sustain recovery).
7. Methadone hurts your health, e.g., rots your bones and teeth.[580]	7. The safety of methadone, including its safety for pregnant women and the infants they deliver, has been established in innumerable scientific studies.[581] Most side-effects reported by patients are not a function of methadone per se, but are due to "inadequate dosages which precipitate withdrawal symptoms, excessive amounts of methadone, undiagnosed medical problems, or the interaction of methadone with other drugs and/or alcohol."[582] Long-term health problems, specifically dental disease, result from years of avoiding medical/dental care and are often first identified when the person enters MAT.
8. Methadone makes you fat.	8. Weight gain is common among MAT patients and is a product of increased food intake and improvement in overall health. Weight stabilizes with improved nutrition and exercise.[583]
9. MAT patients are at increased risk of developing alcohol problems.	9. Problems of secondary drug dependence are a risk factor for all persons in recovery from opioid addiction, but this risk is similar across modalities of treatment. These problems are elevated in MAT programs that use sub-optimal doses of methadone and do not clinically address the problem of co-occurring psychiatric illness and secondary drug use—particularly the "pill culture" (e.g., benzodiazepines) that permeates many methadone clinics. The lack of meaningful activities may also contribute to such secondary drug use among MAT patients.[584]

580. Beschner, G.M., & Walters, J.M. (1985). Just another habit? The heroin users' perspective on treatment. In B. Hanson, G. Beschner, J.M. Walters, & E. Bovelle (Eds.), *Life with heroin: Voices from the inner city.* Lexington, MA: Lexington Books.

581. Kreek, M.J. (1983). Health consequences associated with the use of methadone. In J. R. Cooper, F. Altman, B.S. Brown, & D. Czechowicz (Eds.), *Research on the treatment of narcotic addiction: State of the art* (NIDA Research Monograph Series; DHHS Publication No. (ADM) 83-1281; pp. 456-482). Rockville, MD: National Institute on Drug Abuse. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. Center for Substance Abuse Treatment (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048). Rockville, MD: Substance Abuse and Mental Health Services Administration.

582. Goldsmith, D.S., Hunt, D.E., Litpon, D.S., & Strug, D.L. (1984). Methadone folklore: Beliefs about side effects and their impact on treatment. *Human Organization*, *43*(4), 330-340.

583. Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides).

584. Best, D. (2009). Personal communication.

THE MYTH	THE FACTS
10. Methadone blunts the emotions, e.g., references to "methadone mummies."	10. MAT patients actually report increased capacity to acknowledge and express emotion.[585] The blunting of emotion might result from excessive methadone doses or secondary use of other drugs, e.g., benzodiazepines.
11. Methadone maintenance is for "losers." It is for people who can no longer "take care of business" on the streets.[586]	11. "This image of the methadone client as a 'loser,' without 'heart,' and unable to 'make it on the streets anymore,' is reinforced by the low visibility of methadone clients who are working regularly and/or have what both clients and users not in treatment describe as a 'steady hustle,' that is, regular, income-generating employment, either legal or illegal."[587]
12. Methadone is a tool of political pacification of poor communities of color.	12. Methadone makes a positive contribution to poor communities of color via reduced heroin-related deaths, reduced transmission of HIV and other diseases, reduced crime, and the social and economic assets that stable MAT patients add to their communities. Anti-methadone attitudes within the African American community must be viewed within the context of a long history of victimization of this community by scientific and medical enterprises, e.g., withholding medical treatment from 399 African American sharecroppers in the Tuskegee Syphilis Study.[588]

Sources: Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions, 20(*11-12), 1751-1171; Velton, E. (1992). Myths about methadone. National Alliance of Methadone Advocates, *Education Series Number 3*; Joseph, H., Stancliff, S. & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine,* 67, 347-364.

Again, these myths inhibit help-seeking, contribute to ambivalence about treatment, and increase the likelihood of treatment disengagement of MAT patients.[589]

585. Flynn, P.M., Joe, G.W., Broome, K.M. Simpson, D.D., & Brown, B.S. (2003). Recovery from opioid addiction in DATOS. *Journal of Substance Abuse Treatment*, *25*(3), 177-186.

586. Preble, E., & Casey, J. (1969). Taking care of business—The heroin user's life on the street. *The International Journal of the Addictions*, *6*(1), 1-24. Preble, E., & Miller. T. (1977). Methadone, wine and welfare. In R.S. Weppner (Ed.), *Street ethnography* (pp. 229-248). Beverly Hills: Sage Publications.

587. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

588. White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

589. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": The image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Rosenblum, A., Magura, S., & Joseph, H. (1991). Ambivalence toward methadone treatment among intravenous drug users. *Journal of Psychoactive Drugs*, *23*(1), 21-27.

EXAMPLES OF ADDICTION/TREATMENT/RECOVERY-RELATED STIGMA/ DISCRIMINATION

Addiction-related stigma is manifested in a broad range of attitudes, behaviors, and policies. These general effects include:

- Social shunning/distancing
- Expression of disregard and contempt
- Denial of needed medication for pain (interpreting expressions of pain as drug-seeking behavior)
- Disrespect from primary health care providers and social service personnel
- Denial of basic medical services
- Denial of liver transplantation
- Discrimination via denial of governmental benefits for people with drug-related felonies, e.g., student loans, public housing, small business loans
- Denial of training/employment opportunities
- Denial of housing and homelessness services

Other effects of such stigma are reserved specifically for those persons whose treatment and recovery is supported by methadone. These more specific effects include:

- Denial of methadone support or medically-supervised withdrawal during incarceration
- Denial of access to other addiction treatment modalities and recovery support services, e.g., denial of access to many residential treatment facilities and recovery homes in spite of evidence that persons on methadone can benefit on par with non-medicated patients from such services[590]
- Denial of medication for pain on the false assumption that pain is relieved by the existing methadone dose
- Exposure to punitive, as opposed to supportive, styles of counseling

590. De Leon, G., Stains, G.L., Perlis, T.E., Sacks, S., McKendrick, K., Hilton, R., & Brady, R. (1995). Therapeutic community methods in methadone maintenance (Passages): An open clinical trial. *Drug and Alcohol Dependence, 37*, 45-57. Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guydish, J., Masson, C.L., et al. (2008). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, *100*(1), 100-109.

- Denial of the right to speak and assume leadership roles in local AA/NA meetings
- Denial of detoxification services for other addictive substances in acute medical facilities (e.g., medical management of alcohol withdrawal) while being maintained on one's prescribed and stabilized dose of methadone[591]
- Loss of child custody due to participation in MAT.

The stigma attached to addiction, and to the use of methadone as a medication in particular, has influenced key clinical practices within methadone treatment since its inception in the mid-1960s. Such practices, often "legislated" by oversight bodies, further contributed to the stigma associated with methadone treatment.[592] These practices, some of which have declined due to changes in regulatory guidelines, include:

- Resistance to hiring methadone patients as counselors (e.g., requirement that they first be tapered)
- Being required to stand in line in a publicly visible area (e.g., public sidewalk) to receive methadone
- Separate bathrooms for staff and patients (required by regulation in most states)
- Refusing to admit people on the grounds of insufficient motivation
- Informal use of pejorative labels to designate readmitted patients (e.g., *frequent flyers, re-treads*)
- Lowered "horizons of possibilities" (expectations) communicated to patients
- Suboptimal methadone doses
- Lowering methadone dose or disciplinary discharge as a punishment for clinic rule violations
- Discharging patients for drug use[593]
- "Blind dosing" without patients' involvement and consent
- Stigma attached to having a high dose of methadone within the MAT subculture
- Staff pressure on patients to taper (medically withdraw) from methadone in settings with an abstinence orientation toward MAT

---

591. Hettema, J., & Sorenson, J.L. (2009). Access to care for methadone maintenance patients in the United States. *International Journal of Mental Health and Addiction*. Online publication ahead of print. Retrieved from http://www.springerlink.com/content/c5v56125880u2p64/. Joe, G.W., Simpson, D.D, & Rowan-Szal, G.A. (2009). Interaction of counseling rapport and topics discussed in sessions with methadone treatment clients. *Substance Use and Misuse*, *44*, 3-17. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

592. Anstice, S., Strike, C.J., & Brands, B. (2009). Supervised methadone consumption: Client issues and stigma. *Substance Use and Misuse, 44*(6), 794-808. O'Brien, C.P. (2008). A 50 year old woman addicted to heron: Review of treatment for heroin addiction. *Journal of the American Medical Association*, *300*, 414-321.

593. NAMA (1994). Discharge from treatment for drug use. Policy statement # 3. Retrieved May 25, 2009 from http://www.methadone.org/namadocuments/ps03discharge_from.html.

- Staff discouragement of tapering for all patients out of fear "they won't make it" in settings with a harm-reduction orientation toward MAT
- Onerous pickup schedules and restricted dispensing hours that interfere with pro-social roles, e.g., education, employment, parenting
- Supervised consumption of methadone and frontally observed urine drops (required by regulation)
- Arbitrary limits on the duration of methadone maintenance
- Discouragement/prohibition of fraternization among MAT patients
- Inadequate funding/reimbursement for ancillary health and social services, inadequate education and training of staff, and inadequate clinical supervision
- Elaborate and medically unprecedented regulatory requirements governing the use of methadone as a medication in addiction treatment.[594]

In the MAT context, these practices are often experienced by patients as a demonstration of the power held over them by professional staff. There are evidence-based training strategies and techniques that can lower stigma and its behavioral manifestations displayed by frontline addiction treatment service providers.[595]

Methadone-specific stigma can also affect methadone treatment organizations and their staff. Organizational effects can include community resistance to the opening of a new methadone treatment site, resistance to the relocation of an existing program, or political pressure to close an existing MAT site.

CONCEPTUAL UNDERPINNINGS OF A CAMPAIGN TO ELIMINATE STIGMA RELATED TO METHADONE

Anti-stigma campaigns in the addictions arena have historically focused on a core set of ideas.[596] These simply stated propositions serve as the skeletal foundation of professional and public education efforts and policy advocacy efforts. For example, the "modern alcoholism movement" launched in the 1940s laid the foundation for the rise of modern addiction treatment. This movement was built on the five "kinetic" ideas:

---

594. Järvinen, M., & Andersen, D. (2009). The making of the chronic addict. *Substance Use and Misuse*, *44*, 865-885. Rosenbaum, M. (1995). The demedicalization of methadone maintenance. *Journal of Psychoactive Drugs*, *27*, 145-149.

595. Andrews, S.B., Sorenson, J.L., & Delucchi, K. (2004). *Methadone stigma and the potential effect of sensitivity training for drug treatment staff*. Presented at the annual meeting of the American Public Health Association, November 6-10, Washington, DC. Hayes, S.C., Bissett, R., Roget, N., Padilla, M., Kohlenberg, B.S., Fisher, G., et al. (2004). The impact of acceptance and commitment training and multicultural training on the stigmatizing attitudes and professional burnout of substance abuse counselors. *Behavior Therapy, 35*(4), 821-835.

596. Johnson, B. (1973). *The alcoholism movement in America: A study in cultural innovation.* Unpublished doctoral dissertation, University of Illinois, Urbana, Illinois.

Modern Alcoholism Movement: 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.[597]

New Recovery Advocacy Movement: Core Ideas

The "new addiction recovery advocacy movement" is also based on a set of core ideas:

1. Addiction recovery is a reality in the lives of hundreds of thousands of individuals and families throughout the United States.
2. There are many paths to recovery, and all are cause for celebration.
3. Recovering and recovered people are part of the solution to alcohol and other drug problems.
4. Recovery flourishes in supportive communities.
5. Recovery is voluntary.
6. Recovery gives back what addiction has taken from individuals, families, neighborhoods, and communities.[598]

Any movement to destigmatize methadone treatment and the broader arena of medication-assisted recovery will need its own set of core ideas. The propositions listed below constitute a menu of propositions from which such a set of ideas might be formulated and condensed to form operational slogans.

THE NATURE OF ADDICTIVE DISORDERS

- The initial decision to consume or not consume alcohol, tobacco, and other drugs is, in most but not all circumstances, a voluntary choice.[599]

---

597. Anderson, D. (1942). Alcohol and public opinion. *Quarterly Journal of Studies on Alcohol*, *3*(3), 376-392. Mann, M. (1944). Formation of a National Committee for Education on Alcoholism. *Quarterly Journal of Studies on Alcohol, 5*(2), 354-358.

598. 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.

599. Dr. Karol Kaltenbach and others point out that multiple factors compromise the volitional intent involved in initial drug consumption: early age of onset, introduction of drug use by an older authority figure, coerced use as a dimension of sexual victimization, and drug-saturated peer environments can all compromise the voluntary quality of such choices.

- This initial choice may be consciously influenced by moral or religious values,[600] but more often reflects behavior directed at normal needs and experiences, e.g., pleasure seeking, social inclusion, personal identity, relief from physical/emotional discomfort or family distress.
- The long-term consequences flowing from continued drug exposure have more to do with factors of personal and environmental vulnerability than with personal morality or strength of character.
- Addiction is a brain disease that manifests itself in the loss of volitional control over drug-seeking, drug use, and its consequences.
- This loss of volitional control is related to neurobiological changes in the brain that place the need for the drug above other physical needs and social responsibilities.
- Addiction is not a problem easily resolved through "willpower"; addiction is, by definition, a failure of such power.
- Nearly two-thirds of American families have direct experience with alcohol or drug addiction.[601]

NATURE OF ADDICTION RECOVERY

- Recovery from alcohol and drug addiction requires personal persistence and sustained family and social support; recovery flourishes in supportive communities.
- Recovery-supportive communities are good for everyone; all citizens reap dividends from successful long-term recovery.
- Long-term addiction recovery is a living reality for hundreds of thousands of individuals and families.
- Recovery from alcohol and drug addiction requires personal persistence and sustained family and social support; recovery flourishes in supportive communities.
- There are multiple pathways of long-term recovery, and all are cause for celebration.
- Providing addiction treatment and sustained recovery support services is more effective and a more prudent use of community resources than the strategy of mass incarceration.

---

600. Husak, D.N. (2004). The moral relevance of addiction. *Substance Use and Misuse, 39*(3), 399-436.

601. Peter D. Hart Research Associates/Coldwater Corporation (2004). *2004 Peter D. Hart Research Associates/Coldwater Corporation, Faces and Voices of Recovery public survey.* Washington, DC: Faces and Voices of Recovery.

MEDICATION AND RECOVERY

- Some opioid-dependent individuals with sustained abstinence from short-acting opioids and social support may achieve long-term recovery (brain recovery and psychosocial recovery) without the aid of medications, while other drug-dependent individuals will require prolonged, if not lifelong, use of medications that reduce drug craving and facilitate full biopsychosocial/spiritual functioning.
- Stabilizing medications are available for the treatment of severe opioid addiction, and even more effective medications may become available in the future.
- Opiate addiction is a "brain-related medical disorder" that is treatable with effective medications; other professionally directed medical, psychological, and social services; and peer-based recovery support services.[602]
- Appropriate daily dosages of methadone suppress cellular craving for narcotics, prevent withdrawal symptoms (the opioid abstinence syndrome); block the effects of heroin use; and provide a platform or metabolic stability upon which full physical, emotional, and cognitive recovery can be achieved.[603]
- The dosages required to achieve these effects vary from individual to individual.[604]
- Appropriate oral doses of methadone do not produce an experience of sedation or euphoria in individuals who are opiate-tolerant;[605] stabilized patients not using other substances are capable of experiencing the full range of emotional and physical pain.[606]
- Methadone maintenance combined with needed ancillary medical, psychological, and social services is the most effective method of treating chronic heroin addiction.[607]
- The effectiveness of methadone maintenance treatment has been reviewed and affirmed by major health research and policy bodies, including the National Institute on Drug Abuse, the American Medical Association, the American Society of Addiction Medicine, the Institute of Medicine, the National Academy of Sciences, the National Institute on Health Consensus Panel, and the Office of National Drug Control Policy,[608] as well as the World Health Organization and other governmental health policy groups around the world.

---

602. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158.

603. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

604. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

605. Marion, I.J. (2009). Methadone: Myths and Facts (Presentation slides); Murray, J.B. (1998). Effectiveness of methadone maintenance for heroin addiction. *Psychological Reports*, *83*, 295-302. Zweben, J. (1991). Counseling issues in methadone treatment. *Journal of Psychoactive Drugs*, *23*(2), 177-190.

606. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

607. Rettig, R.A., & Yarmolinsky, A. (1995). *Federal regulation of methadone treatment*. Washington, D.C.: National Academy Press. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

608. White, W., & Coon, B. (2003). Methadone and the anti-medication bias in addiction treatment. *Counselor*, *4*(5), 58-63.

- These collective reviews conclude that orally administered methadone can be provided for a prolonged period at stable dosages with a high degree of safety and without significant effects on psychomotor or cognitive functioning.[609]
- Methadone is the safest medication available to treat heroin addiction in pregnant women.[610]
- These reviews also confirm that MAT delivered at optimal dosages by competent practitioners: 1) decreases the death rate of opiate-dependent individuals by as much as 50%; 2) reduces the transmission of HIV (four-to-six-fold reductions), 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.[611]
- Methadone-related deaths are related primarily to the diversion of methadone prescriptions for pain rather than from methadone used as a treatment for addiction or illegally diverted from methadone clinics/patients.[612]
- Methadone as a pharmacological adjunct in the treatment of opioid addiction, like insulin in the treatment of diabetes, is a corrective therapy, not a curative therapy. It is effective only when it is consumed on a sustained daily basis. Relapse rates are high following cessation of methadone maintenance, and mortality rates rise following medical withdrawal.[613] People should not be precipitously encouraged to end such treatment.[614] Patients choosing to taper (end methadone maintenance) should receive increased program support, including educational guidance on the tapering decision, relapse prevention, and recovery strengthening techniques; support for changes in diet and exercise; continued professional and peer-based support; close post-tapering monitoring; and, if and when needed, early re-intervention and re-initiation of methadone maintenance.[615]
- After more than 40 years' experience with methadone maintenance, primary addiction to methadone within the illicit drug culture occurs but still constitutes a rare phenomenon. Methadone has value in the illicit drug culture primarily for the self-medication of opiate-dependent individuals who cannot procure heroin or other short-acting opioids, or who cannot gain access to methadone maintenance programs.[616]

---

609. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

610. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105.

611. Clausen, T., Ancherson, K., & Waal, H. (2008). Mortality prior to, during and after opioid maintenance treatment (OMT): A national prospective study. *Drug and Alcohol Dependence*, *94*, 151-157. Corsi, K.F., Lehman, W.K. & Booth, R.E. (2009). The effect of methadone maintenance on positive outcomes for opiate injection drug users. *Journal of Substance Abuse Treatment*, *37*, 120-126. Kreek, M.J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943.

612. Paulozzi, L.J., Budnitz, D.S., & Xi, Y. (2006). Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiology and Drug Safety*, *15*(9), 618-27. Sims, S.A., Snow, L.A., & Porucznik, C.A. (2006). Surveillance of methadone-related adverse drug events using multiple public health data sources. *Journal of Biomedical Information, 40*(4), 382-389. Webster, L.R. (2005). Methadone-related deaths. *Journal of Opioid Management*, *1*, 211-217.

613. Davoli, M., Bargagli. A.M., Perucci C.A., Schifano, P., Belleudi, V., Hickman, M., et al. (2007). Risk of fatal overdose during and after specialist drug treatment: The VEdeTTE study: A national multi-site prospective cohort study. *Addiction*, *102*, 1954-1959. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

614. Cooper, J.R. (1992). Ineffective use of psychoactive drugs: Methadone is no exception. *Journal of the American Medical Association*, *267*(2), 281-282.

615. Gold, M.L., Sorenson, J.L., McCanlies, N., Trier, M., & Dlugosch, G. (1988). Tapering from methadone maintenance: Attitudes of clients and staff. *Journal of Substance Abuse Treatment*, *5*, 37-44. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

616. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171. Joseph, H., Stancliff, S., & Langrod, J. (2000). Methadone maintenance treatment: A review of historical and clinical issues. *Mount Sinai Journal of Medicine*, *67*, 347-364.

STIGMA AS A BARRIER TO RECOVERY

- The stigma attached to addiction, treatment, and recovery injures those—the patient and family—directly affected by these experiences, as well as the larger community.[617]
- The stigma attached to addiction perpetuates the very problem it is intended to discourage.
- There is substantial shame embedded in the experience of addiction; people in need of addiction treatment should not be shamed for seeking the very resources that may be critical to their long-term recovery. Yet entry into methadone maintenance, because of the attached stigma, is often experienced as failure as a person—and even failure as an addict.[618]

AN ADDICTION/TREATMENT/RECOVERY CAMPAIGN

The stigma attached specifically to methadone maintenance is embedded at the community level within a larger body of negative attitudes toward illicit drug use, drug addiction, addiction treatment, and addiction recovery. The best stigma-reduction campaign would aim at general attitudes toward addiction, treatment, and recovery, with a sub-campaign that specifically addresses stigma related to methadone and other medications.

Guiding Vision: Create a city and 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."[619]

Campaign Goals: To:

- Change public and professional views on methadone maintenance treatment from a practice that just "substitutes one drug/addiction for another" to a scientifically validated medical practice capable of saving and transforming lives and enhancing the quality of community life.[620]
- Change the view of methadone maintenance within the heroin using community from that of a passive process of "giving up" to an assertive lifestyle of active recovery.[621]
- Put a face and voice on medication-assisted recovery by conveying the stories of individuals and families in long-term addiction recovery and explaining the role MAT programs are playing in enhancing the health and safety of particular neighborhoods.

---

617. Lavack, A. (2007). Using social marketing to de-stigmatize addictions: A review. *Addiction Research and Theory, 15*(5), 479-492.

618. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

619. Substance Abuse and Mental Health Services Administration (SAMHSA) (2002). *National Recovery Month helps reduce stigma*. Substance Abuse and Mental Health Services Administration. Retrieved June 17, 2009 from http://www.hazelden.org/web/public/ade20909.page.

620. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

621. Hunt, D.E., Litpon, D.S., Goldsmith, D.S., Strug, D.L., & Spunt, B. (1985). "It takes your heart": the image of methadone maintenance in the addict world and the effect on recruitment into treatment. *International Journal of the Addictions*, *20*(11-12), 1751-1171.

- Portray the contributions of people in medication-assisted recovery to their communities through their family support, educational, occupational, and community service activities.
- Encourage participation of MAT providers in local community activities to improve the public image of the methadone clinic/patient.

A Menu of Potential Strategies: Listed below is a menu of potential strategies that might be refined and implemented to achieve the goals outlined above. These potential strategies, developed by the Philadelphia Department of Behavioral Health and Mental Retardation Services, are offered as a starting point for local discussion.

RECOVERY REPRESENTATION AND COMMUNITY MOBILIZATION

1. Ensure broad representation of people in medication-assisted recovery and professional representation from medication-assisted treatment providers within policy advisory groups and technical work groups.
2. Create an organizational structure to lead a campaign to define and promote methadone-assisted recovery initiation and recovery maintenance (sobriety, global health, and citizenship) as a morally honorable pathway of long-term recovery. Try to elevate the legitimacy and visibility of the campaign via local political sponsorship, e.g., a mayoral commission.
3. Encourage the inclusion of people in medication-assisted recovery in existing recovery support fellowships and develop/support recovery fellowships specifically for people in medication-assisted recovery, e.g., Methadone Anonymous.[622] (The encouragement and use of recovery support groups has significantly increased in MAT clinics in the United States, and the M.A.R.S. Project in New York City is receiving many requests for information about such support groups).[623]
4. Encourage the development of venues through which people in recovery (particularly current or former MAT patients) can perform acts of service to those seeking recovery, as well as broader acts of community service.
5. Create a Mayor's Task Force to assist in the planned relocation of existing treatment programs or site locations for new programs—proactive management of "Not in my backyard" (NIMBY) resistance by establishing principles for locating addiction treatment and recovery support resources. (This may be best addressed within a Task Force that explores siting issues for all

622. Gilman, S.M., Galanter, M., & Dermatis, H. (2001). Methadone Anonymous: A 12-step program for methadone maintained heroin addicts. *Substance Abuse*, *22*(4), 247-256. Glickman, L. Galanter, M., Dermatis, H., & Dingle, S. (2006). Recovery and spiritual transformation among peer leaders of a modified Methadone Anonymous group. *Journal of Psychoactive Drugs*, *38*(4), 531-533. Obuchowsky, M., & Zweben, J.E. (1987). Bridging the gap: The methadone client in 12-Step programs. *Journal of Psychoactive Drugs*, *19*(3), 301-302.

623. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

health and social service programs.) Those principles identified earlier in this article might serve as beginning points for discussion.

6. Explore ways to use patient writing, art, drama, music, dance, and videography as vehicles of education on medication-assisted treatment and recovery.

COMMUNITY EDUCATION

1. Design, implement, and evaluate a public education campaign (similar to the drunk driving media campaigns of the 1980s and California's Methadone Saves Lives campaign) through a Mayor's task force that would include representatives from all major local media outlets.
   - Put mainstream faces and voices on addiction, treatment, and recovery.
   - Include the faces of family members whose lives have been influenced by addiction treatment and recovery.
   - Embed information on opioid addiction and medication-assisted recovery in mainstream healthcare outlets, e.g., medical clinics, pharmacies, health fairs, etc.
   - Target those zip codes experiencing the most severe opioid dependence problems.
2. Establish interdisciplinary work groups who, as part of the Mayor's task force, will be charged with: developing/disseminating articles, pamphlets, and training materials on medication-assisted recovery aimed at reaching local lay and professional audiences; placing articles in media outlets; and immediately responding to inaccurate portrayals of medication-assisted treatment/recovery by the media.[624]
3. Develop *and support* a corps of people who, through interviews and speeches, can put a positive face and voice on medication-assisted recovery; recruit people in medication-assisted recovery for participation in Storytelling Training;[625] organize speaking teams of professionals and recovery advocates who can speak to local groups; and develop information packets to support the work of these teams.
4. Develop brief information packets and oral presentations that can be used by outreach workers to challenge "street mythologies" on methadone and other medications used in the treatment of addiction.

---

624. Jones, D.J. (2002). Methadone patient advocacy—letters to the media helps change attitudes. *Methadone Today, 6*(9), 4. Joseph, H. (1995). *Medical methadone maintenance: The further concealment of a stigmatized condition*. Unpublished doctoral dissertation, City University of New York.

625. Storytelling Training is a skills-based training for persons in recovery to assist them in developing their recovery stories and gaining confidence in refining and presenting those stories in public and professional forums.

PROFESSIONAL EDUCATION

1. Create opportunities for people throughout the treatment system to be exposed to the faces and voices of people in long-term medication-assisted recovery.
2. Ensure that all staff and volunteers working within addiction treatment are educated about the effectiveness of medication-assisted treatment, myths versus scientific findings on methadone maintenance, the importance of proper dosing in medication-assisted treatment, comparative outcomes of medication-assisted and drug-free treatment, and post-treatment outcomes for both medication-assisted and drug-free treatment.[626] On a monthly basis, provide a centralized orientation for all new staff entering the Philadelphia treatment system, with the above information included.[627]
3. Provide structured opportunities for staff exchanges between medication-assisted and drug-free treatment programs, exchanges that include opportunities for formal and informal interactions with staff and patients. Ensure admission policies/practices that allow people in medication-assisted treatment to receive collateral treatment and recovery support services from other addiction treatment and recovery support organizations, e.g. the integrated treatment of methadone patients for co-occurring alcohol dependence within alcoholism treatment programs.[628]
4. Ensure that scientifically grounded information on medication-assisted recovery is included in local addiction studies programs and within the in-service training programs of all funded addiction treatment programs.
5. Integrate information on medication-assisted addiction treatment into the curricula of local medical schools, and host an annual training for local physicians and psychiatrists on the use of medications in the treatment of addiction and best practices for pain management in patients being treated for addiction with methadone or buprenorphine. Provide information and resources on persons in medication-assisted recovery for use in psychology, social work, and allied health professional training programs.
6. Ensure that all managed care behavioral health organizations (MCBHOs) include an adequate number of panel providers with experience or training in the area of medication-assisted opioid treatment and pain management.

---

626. Kang, S-Y, Magura, S., Nwakese, P., & Demsky, S. (1997). Counselor attitudes in methadone maintenance. *Journal of Maintenance in the Addictions*, *1*(2), 41-58.

627. Recent studies—Abraham, A.J., Ducharme, L. & Roman, P. (2009). Counselor attitudes toward pharmacotherapies for alcohol dependence, *Journal of Studies of Alcohol and Drugs*, *70*, 628-635—suggest that counselors are quite receptive to pharmacological adjuncts in the treatment of alcohol dependence when given proper training on the use of such adjuncts. The extent to which these findings would extend to receptiveness to methadone with similar training is unclear.

628. Kipnis, S.S., Herron, A., Perez, J., & Joseph, H. (2001). Integrating the methadone patient in the traditional addiction inpatient rehabilitation program—problems and solutions. *The Mount Sinai Journal of Medicine*, *68*(1), 28-32.

7. Host a training on medication-assisted treatment for key criminal justice personnel to police (via police academy), jail staff, attorneys, and judges—particularly criminal court, drug court, and family court judges. This is of paramount importance to the well being pregnant and parenting women.[629]
8. Provide orientation to treatment and medication-assisted treatment to key city officials—both political leaders and department heads and supervisors.

NON-STIGMATIZING, RECOVERY-FOCUSED LANGUAGE

1. Conduct an audit of the core concepts and language of addiction treatment and recovery, purging language that perpetuates myths, misunderstandings, and stigma and replacing that language with words and phrases that convey respect and hope for multiple pathways of long-term recovery.
2. Purge language that grew out of moral models of addiction, e.g., *dirty/clean*. Clarify the meaning of *drug free, abstinence, sobriety,* and *recovery*. Promote the Betty Ford Institute's (BFI) three-component consensus definition of recovery: sobriety, global health, and citizenship, in which "formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety."[630]
3. Use the BFI recovery definition in order to achieve conceptual clarity and expose the abstinence-versus-methadone debate as a false dichotomy. The issue is not one of method but of mission: full recovery and a meaningful life in the community—by any means necessary. By the BFI definition of recovery, there are individuals who are abstinent from all psychoactive drugs who do not meet the criteria for recovery and individuals maintained on methadone who do meet those criteria. Recovery is more than the elimination of alcohol and drugs from an otherwise unchanged life, and recovery is more than medication-facilitated metabolic stabilization. The BFI definition of recovery may help address stigma and discrimination at both professional and public levels.
4. Encourage members of Methadone Anonymous to advocate for a change in the name of the fellowship to something that does not equate methadone with heroin (e.g., Medication-Assisted Recovery Anonymous). Many other anonymous fellowships include in their names the drug or activity to be given up, e.g., Narcotics Anonymous, Cocaine Anonymous, Crystal

629. Dr. Karol Kaltenbach (2009). Personal communication.

630. Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*, 221-228.

Meth Anonymous, Gamblers Anonymous. This is not the explicit intent of Methadone Anonymous, but that is what is currently being conveyed via its name.[631]

5. Develop a policy statement on language and stigma for dissemination to all DBH/MRS-funded treatment programs.

6. Cease describing methadone maintenance in terms that suggest the equivalency of heroin and methadone, such as *substitution therapy* or *replacement therapy*, and the use of the term *detoxification* to describe tapering (methadone is a medication, not a toxic substance). Replace such language with words and phrases that convey the link between methadone and long-term recovery, e.g., *medication-assisted treatment* and *medication-assisted recovery*.[632]

> *Dole and Nyswander would never prescribe a "substitute" for heroin. When Dole used the term "replacement therapy," he meant it in a physiological sense—that there were impairments in the central nervous system caused by the continuous use of opiates and that methadone could correct but not cure these impairments. He did not mean that methadone replaces heroin as a legal intoxicant. Methadone is a corrective medication, not a substitute for heroin.*[633]

TREATMENT PRACTICES

1. Change institutional identities of medication-assisted treatment providers from "methadone clinics" to "addiction recovery centers"—as is currently being attempted in the State of New York. This would signal the institutional mission of recovery and identify medication as one of many tools that can help people achieve that goal. Encourage patients to participate in a broad menu of professionally directed and peer-based recovery support activities at the clinic or at a closely located recovery support center. Build strong cultures of recovery—a recovery haven, refuge, sanctuary—within or in proximity to existing clinics. Expose the least stabilized patients to role models who have achieved successful stabilization and long-term recovery.[634]

2. Explore regulatory and funding policy changes that would allow addiction treatment and recovery support services to be provided in less stigmatized sites, e.g., mainstream health care delivery institutions, schools, churches, neighborhood centers, and other community service organizations.[635] Expand medical methadone maintenance-methadone provided to the most stabilized patients via a monthly visit to a private health practitioner.[636]

---

631. NAMA (1995). On the name of Methadone Anonymous. National Alliance of Methadone Advocates, inc, Policy Statement # 6, May, 1994. Retrieved July 28, 2009 from http://www.methadone.org/namadocuments/ps06ma_name.html.

632. Maremmani, I., & Pacini, M. (2006). Combating the stigma: Discarding the label "substitution treatment" in favour of "behavior-normalization treatment." *Heroin Addiction and Related Clinical Problems*, *8*(4), 5-8. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009. Ginter, W. (2009). Personal Communication (Interview), June 22, 2009.

633. Joseph, H. (2009). Personal Communication (Interview), June 5, 2009.

634. Until opioid treatment programs as a whole develop such vibrant cultures of recovery, they will be vulnerable to collective charge that they have done little more than transition their patients from an active life of hustling and getting high to a life of "methadone, wine and welfare". Prebble, E., & Miller. T. (1977). Methadone, wine and welfare. In R. S. Weppner (Ed.), *Street ethnography* (pp. 229-248). Beverly Hills: Sage Publications.

635. Radcliffe, P., & Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatized identities. *Social Science and Medicine, 67*(7), 1065-1073.

636. King, V.L., Burke, C., Stoller, K.B., Neufeld, K.J., Peirce, J., Kolodner, K., et al. (2008). Implementing methadone medical maintenance in community-based clinics: Disseminating evidence-based treatment. *Journal of Substance Abuse Treatment*, *35*, 312-321. Marion, I.J. (2009). Personal communication with author, June 24, 2009.

3. Prohibit the exclusion of persons on methadone or buprenorphine by any organization receiving funding. This would add authority to existing regulations prohibiting organizations receiving city/state/federal dollars to discriminate against MAT recipients. Any communication from public authorities regarding such prohibition should also include the reminder that MAT recipients are protected under the American Disabilities Act.
4. Improve the public image of methadone clinics by upgrading the exterior and maintenance of the physical plant; improve the quality of the clinic visit experience by upgrading the quality and maintenance of the interior physical plant of methadone clinics. Increase the use of "warm welcome" procedures, including casual dress by security personnel.
5. Facilitate greater integration between harm reduction (HR) projects (needle-exchange programs), medication-assisted treatment, and medication-focused recovery advocacy, e.g., pilot programs that infuse clearer recovery options into HR, such as recovery-focused outreach workers available at needle exchange sites.

LOCAL, STATE, AND FEDERAL POLICY ADVOCACY

1. Encourage the development of medication-assisted recovery advocacy groups, e.g., local chapters of the National Alliance for Medication-Assisted Recovery (NAMA Recovery), and/or the inclusion of people in medication-assisted recovery within existing or emerging recovery advocacy organizations.
2. Encourage medication-assisted treatment providers to continue their advocacy activities through state Associations for the Treatment of Opioid Dependence and the American Association for the Treatment of Opioid Attendance (AATOD) related to federal, state, and local policy/regulatory/funding/research issues.
3. Seek alignment of policies, funding guidelines, and mechanism and regulatory guidelines to support recovery-focused treatment of chronic opioid dependence.
4. Encourage individuals and organizations to seek full legal redress in response to acts of discrimination related to medication-assisted treatment and recovery.

EVALUATION

1. Establish a baseline of community attitudes and practices—among citizens, addiction treatment providers, allied health and human service providers, criminal justice personnel, child protection personnel, and members of recovery support fellowships—for use in evaluating this overall plan over time.

The implementation of some of these strategies will require a vanguard of people in methadone-assisted recovery to involve themselves in a larger recovery advocacy movement. Efforts must be made to encourage and support that vanguard.

SUMMARY

The social stigma attached to addiction, addiction treatment, and addiction recovery exists at cultural, institutional, interpersonal, and intrapersonal levels.[637] This stigma is particularly intense for those with histories of heroin self-injection and who are in medication-assisted treatment. Efforts to lower stigma and discrimination for those in addiction treatment and recovery, particularly those in MAT, will need to operate at all these levels. Commitment at the highest levels is essential to the mobilization of citizens to support policies and programs that support long-term personal and family recovery from alcohol and other drug problems, and to provide services to youth aimed at breaking intergenerational cycles of alcohol and other drug problem transmission in individuals, families, and neighborhoods. It is essential to engage multiple stakeholders in formulating strategies to reduce social stigma related to addiction treatment and recovery and to take special action to reduce the stigma related to medication-assisted treatment and recovery. Through this process, we will use one guiding principle: *There are multiple pathways of long-term addiction recovery, and all are cause for celebration.*

637. Woll, P. (2005*). Healing the stigma of addiction: A guide for treatment professionals.* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

About the Authors

William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. **Lisa Torres** (Lisa.Mojer-Torres@dhs.state.nj.us) is a civil rights attorney (admitted to the bars in NY and NJ) providing legal consultation and currently working as the first Consumer & Recovery Advocate for the Division of Addiction Services, Department of Human Services, State of New Jersey. William White and Lisa Torres have served as volunteers for Faces and Voices of Recovery since its inception in 2001.



Institute for Research, Education & Training in Addictions



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: Bamber, S. & White, W. (2011). Bamber-White dialogue I: Recovery-Oriented Methadone Maintenance. Posted at www.williamwhitepapers.com

Bamber-White Dialogue I: Recovery-Oriented Methadone Maintenance

Introduction

In September last year William White and Lisa Mojer-Torres published their landmark monograph Recovery-Oriented Methadone Maintenance. In the months leading up to the publication of the monograph, William and I exchanged a series of emails exploring the nature of recovery, recovery-oriented methadone maintenance and medication assisted recovery in general. We both enjoyed these exchanges and subsequently planned to produce an informal series of dialogues to further consider some of the issues covered in Recovery-Oriented Methadone Maintenance, publish them in a more concise "question-and-answer" format and make them available on our respective websites.

The cluster of questions surrounding medication assisted recovery have a tendency to evoke strong reactions which can obstruct the advancement of knowledge and understanding in this acutely important area. Similarly, the stigma that surrounds methadone and methadone maintenance treatment can act as a barrier to recovery itself: an untenable state of affairs for anyone committed to recovery advocacy in its broadest sense.

Recovery-Oriented Methadone Maintenance is a vitally significant work because for the first time amongst recovery literature a coherent, comprehensive and systematic rationale is provided for the recognition of methadone maintenance as an authentic recovery pathway. Perhaps most notably it helps us identify how we can implement recovery-oriented methadone maintenance across treatment systems in the UK and the US.

The sad passing of Lisa Mojer-Torres on the 5th April this year prompted us to bring a close to this first Dialogue and dedicate it to her memory. It is our hope that this modest piece will inspire people to both read Recovery-Oriented Methadone Maintenance and discover more about the life and work of this inspirational human being.

Stephen Bamber

Dialogue I: Recovery-oriented Methadone Maintenance

Stephen Bamber: I thought we could start by talking a little about your recently released monograph Recovery-Orientated Methadone Maintenance, co-authored with Lisa Mojer-Torres. I wanted to ask you a few questions about the birthing of this monograph. First, what is Recovery-Oriented Methadone Maintenance?

William White: Recovery-Oriented Methadone Maintenance (ROMM henceforth) is a name Lisa Mojer-Torres and I coined to depict an approach to the treatment of opioid addiction that nests science-guided methadone pharmacotherapy within a broader and sustained menu of professional and peer-based support services toward the goal of long-term personal and family recovery. We define personal recovery in the methadone maintenance context in terms of optimum dose stabilization, remission of all substance use disorders and movement towards global health and community reintegration.

Stephen Bamber: Can you communicate the core message of ROMM?

William White: There are four core messages contained in the new monograph, each represented by the four papers that are included:

1. First, the recovery orientation of methadone maintenance (MM)—those service practices now confirmed to be linked to long-term recovery outcomes– diminished during its widespread dissemination and needs to be restored and further developed. MM came to serve many purposes other than personal recovery, and it is our contention that this focus needs to be restored.
2. Second, for MM patients who have achieved recovery as defined above, continued medication maintenance or completion of tapering and sustained recovery without medication support represent varieties or styles of recovery experience and matters of personal choice, not the boundary of passage from the status of addiction to the status of recovery.
3. Third, to achieve this enhanced recovery orientation in methadone maintenance will require substantial changes in prevailing service practices in such arenas as: service attraction, service access, and early engagement; assessment and service planning; service team composition; service relationships; service scope, quality and duration; locus of service delivery; assertive linkage to recovery community resources; as well as long-term recovery check-ups, stage-appropriate recovery education and support, and when needed, early re-intervention.
4. Finally, a major barrier to medication-assisted recovery is the professional and public stigma attached to methadone that will change only through a sustained campaign of professional and public education. That campaign must be led by a vanguard of recovering people whose personal stories offer living proof of the role medication can play in long-term recovery from opioid addiction.

Stephen Bamber: I'm interested in the inspiration behind the work. Was recovery-orientated methadone maintenance a subject you've specifically wanted to address for some time, or did it emerge as an important contribution to methadone and recovery literature that you identified as expedient at this transitional period in the history of drug and alcohol treatment? The field as a whole (to varying degrees) is embracing new modalities and seems more willing to question the orthodoxies and orthopraxis of our extant configurations. It strikes me there is something 'of its time' about ROMM.

William White: The ROMM monograph is the sixth monograph I have authored or co-authored on recovery management and recovery-oriented systems of care (all the monographs can be downloaded at no cost at www.williamwhitepapers.com). When the early monographs came out, people from opioid treatment programs, therapeutic communities, adolescent treatment, drug courts and other treatment venues began asking how to implement this approach in their respective settings. I chose to address methadone maintenance first because it posed the greatest challenges and controversies. I enlisted the help of Lisa Torres, a civil rights attorney and long-time medication-assisted recovery advocate, to assist me, and we in turn engaged the assistance of many professional pioneers of methadone treatment and many current and former methadone patients in successful

long-term recovery. Support for this work came from two of the Center for Substance Abuse Treatment's Addiction Technology Transfer Centers and from the Philadelphia Department of Behavioral Health. The ROMM monograph project was also part of an extended meditation on the multiple pathways and styles of long-term addiction recovery.

Stephen Bamber: ROMM strikes me as being a particularly bold piece of work. I just wondered how that resonates with your experience of writing it? For example, did this piece bring about any particularly unique challenges as a writer, and if so, what were they? I'm particularly mindful of the (small 'p') political dimension to methadone maintenance – something I hope we can discuss in more detail later.

It is a challenge for any writer to explore an issue marked by polarized debate, inflammatory rhetoric and great personal acrimony. The first challenge was to try to rise above the emotions of this debate and to write as a statesperson rather than from any fixed ideological position. We did that by first committing our loyalty to the one party rarely if ever heard in these debates, and that was to people addicted to opioids, particularly those seeking recovery, and to those maintaining their recovery with the aid of methadone. From there it was a challenge of blending the voices of people seeking and in recovery with a sweeping review of the history and science of methadone maintenance. The work required throwing out pre-conceived notions, synthesizing all that we were absorbing and then trying to convey fresh conclusions as clearly and concisely as possible. Time will tell whether we were able to achieve that and whether our effort will have helped create the professional, political and cultural space in which methadone maintenance could be freshly re-examined by both advocates and critics.

Stephen Bamber: I'm curious as to how (if at all) your own thoughts and feelings toward methadone maintenance have been changed during the course of writing this monograph. Are you able to discern any significant shifts in your own thinking that have transpired during this process?

William White: My personal views on methadone maintenance (MM) have undergone profound changes over the course of four decades and through my work on this project. In my early career, I exhibited great animosity toward methadone as a result of my enculturation in drug-free therapeutic communities and Minnesota Model alcoholism programs of the 1960s and 1970s. My early opinions were acquired first by osmosis and then from direct contact with people who had used illicit methadone as an intoxicant or who had used methadone to support their addiction careers—use for respite rather than recovery—and from contact with the least stabilized methadone patients and the worst MM clinics—clinics more nested in the culture of addiction than the culture of recovery. Those experiences all reflect part of the story of methadone and MM treatment, but I had interpreted these experiences as the whole truth.

My attitudes toward methadone began to change when I went back to school and was forced to review the scientific evaluations of MM, but even that stage could be depicted as a begrudging intellectual acceptance of the value of MM for some people. In my gut, I still had deep reservations about MM. I simply had not seen living proof of the connection between methadone and long-term recovery. Then I began to meet a small number of people in methadone-assisted recovery who I admired a great deal and who exemplified what I judged to be an exceptional quality of life and service in recovery—on par with people I admired in recovery without the aid of medication. But I now realize that I still saw these few methadone success stories as morally enlightened exceptions. When the ROMM project started, I believed in the potential of MM as a recovery aid intellectually, but I really did not know if there existed a large pool of people who had achieved full, long-term recovery within the framework of MM. I knew that if they existed

in large numbers, they were well-hidden. It turned out they did exist and that they were exceptionally well-hidden.

The personal turning point in the ROMM project for me was when Lisa and I decided that we needed to hear from patients in long-term methadone-assisted recovery on the issues about which we were writing. We posted notices on methadone advocacy web sites and at methadone clinics that described our project and expressed interest in talking with such people about their experience. Lisa and I did not know what to expect because we really didn't know whether such a significant population existed or its size. What followed was a regular flow of emails and phone calls from long-stabilized patients who shared their recovery stories with us. For me, it was a side of the methadone story that I had never heard or seen in my 40 years working in the addiction treatment field. Nothing has more profoundly changed my views on methadone maintenance than the voices of stabilized methadone patients. Their stories left me convinced of the potential role of methadone in long-term recovery, but appalled by the ways so many of these patients were forced to forge their recoveries not with the help of, but in spite of, the attitudes they encounter from professionals, from local communities of recovery, their own families and their local communities. These patients helped me understand MM in a new way, but even more importantly they changed how I felt about methadone in my belly.

The deeper I got into this project the more my focus shifting from concern about the medication to concern that patients in methadone maintenance were being offered medication and almost none of the other supports that we know are linked to recovery stability, global health and quality of life. In that sense, I think the allegations that methadone has served as a form of social control are apt. We have promoted MM as a strategy to reduce the social costs of addiction in the absence of personal recovery; I would like to return MM to its roots as an aid in the process of personal recovery with reduced social harm being not the primary goal of MM but one of the many positive side-effects of this personal recovery orientation.

The biggest surprise I had in researching the history of MM is that its scientific effectiveness has been established in spite of the absence of important recovery support ingredients as MM was mainstreamed in the U.S. and internationally. It made we wonder what MM outcomes would look like if MM was nested in a vibrant recovery culture and a rich menu of person-centered, professional and peer-based recovery support resources.

Stephen Bamber: Are ROMM and the provision of methadone maintenance as a strategy of harm reduction (HR) philosophically incompatible?

William White: They are not incompatible, but they are perceived as such by many people, particularly those who reap benefit from the increasingly stale and polarized abstinence vs. HR debate. My vision is a simple one: all treatment should seek to reduce harm; all HR strategies should encompass the option, encouragement and support for full, long-term recovery. HR has traditionally been framed in the MM context as the subtraction of negatives—the risks and injuries to self and others that can be eliminated from someone's life; ROMM emphasizes what can be added to someone's life. I think the future rests in seeing HR and recovery as strategies to be uniquely combined and sequenced across the stages/styles of drug use / drug addiction and the stages of recovery rather than as warring ideologies.

Stephen Bamber: To what do you attribute the sometimes extreme resistance to methadone among those who sustain their recoveries without the aid of medication?

William White: There is a tendency for all of us to extend our own experiential truth to the status of universal truth and to then define differences between our own and others' experience in categories of inferiority and superiority. There are many people currently

in recovery who once used methadone as a drug rather than a medication and view their contact with methadone treatment as an extension of their connection to the drug culture—more a part of their addiction career than their recovery career. The animosity they express towards methadone is a means of psychologically distancing themselves from that pattern and from that culture. I think that is understandable, and yet there may be darker forces at work here.

Members of historically disempowered and stigmatized groups are prone to internalize culturally-dominant beliefs about themselves and act them out in their intragroup relationships. The development of status hierarchies and elaborate pecking orders and displacement of aggression within such groups is common. Such hierarchies have long existed in the American drug culture, from the "righteous dope fiend" to the "gutter hype." People in addiction recovery without medical support looking down on people recovering from addiction with medication support is the psychological equivalent of light-skinned African Americans expressing superiority over dark-skinned African Americans, the house slave looking down on the field slave, and the continued pervasiveness of Black-on-Black crime.

I think these mechanisms of introjection and displacement of shame and aggression are at work in the gulf that exists between those recovering with and without the support of medication. I also think these patterns will progressively dissipate as people in recovery and their families mobilize culturally and politically. I think science is also going to help speed this process. We are quite likely to discover that the ability to recovery with or without medication is not a function of strength of character or motivation but differences in genetically-mediated neurophysiology, problem severity and recovery capital. I do think a day is coming when we will see recovery with or without medication as differences in styles of recovery and that recovery by any means necessary under any circumstances will be cause for universal celebration and a prevailing mantra across communities of recovery.

Stephen Bamber: The monograph challenges the gulf between methadone maintenance and traditional drug free treatment. What is your vision for the future of such treatment?

William White: I envision a day when the categories of medication-assisted treatment and "drugfree" treatment will no longer exist—that treatment will no longer be provided in such conceptual and practice silos but will be provided in a setting in which all people seeking help will have a comprehensive menu of services to support them across the stages of recovery. That means that today's methadone maintenance patients would have access to the full range of services now available in traditional drug free treatment settings. That means that today's patients in drug free treatment settings would have a service menu that would include pharmacotherapy support for those who could benefit from it. It would also mean that all people entering treatment would have a larger menu of recovery support services, including peer-based recovery support services, provided over a much more extended period of time analogous to how we now effectively manage other chronic disorders, such as asthma, diabetes, hypertension and cancer. The key to managing those disorders has been to treat them earlier, treat them more holistically and to manage them over the life cycle. That's what we need to do with addiction.

Medication or no medication, I know that recovery involves a reconstruction of personal identity, interpersonal relationships and daily lifestyle. The fact that some people need medication to achieve and sustain stable recovery does not change these broader recovery needs. Adding medication to a treatment milieu does not mean that other critical ingredients of recovery support can or should be deleted. It is my contention that combining the best of "drug free" treatment, medication-assisted treatment and peer-based recovery support services

will create long-term recovery outcomes greater than any of these elements could achieve in isolation. When that day comes, our past sectarian arguments over which approach is best will look petty, if not ridiculous.

Stephen Bamber: I share that belief, Bill. I have always found the most engaging and exciting theoretical accounts of recovery surround the concept of self-transformation. Isn't there a problem with the methadone identity, though? There's a sense of ambivalence about it: it lies rooted in both the culture of addiction and the culture of recovery. Perhaps that's inevitable, to a certain extent. What do you think about that, and what do you think some of the characteristics of a methadone identity rooted solely in a culture of recovery would be? Is it possible?

William White: The social and professional stigma attached to methadone is a burden every methadone patient carries like an indelible stain on the self. There are three aspects to this stigma: our professional understanding of methadone itself, the milieu of MM treatment and the historical baggage attached to social perceptions of methadone and MM. I think the first of these will change in the emerging distinctions between addiction and physical dependence and the growing distinction people in recovery will make between a drug and a medication as an aid to their own recovery management and health care decisions.
Stigma tied to the milieu of methadone treatment will not abate without a recovery focused transformation of that milieu; the identity of the methadone patient cannot change without a change in the milieu of methadone treatment. That identity will change when the meaning of recovery is as fully understood and is as contagious within the MM milieu as it is in the most vibrant of recovery communities.

It remains to be seen whether such a transformation is possible, but I am encouraged by the interest in ROMM by American Opioid Treatment Programs. The social stigma attached to methadone is based on decades of substandard treatment that left many MM patients as socially marginalized as they were in their active heroin addictions. I'm not sure changing that social perception is even possible in the short run and, if so, it will only be by a recovery movement led by stabilized MM patients. I think the best hope would be a combination of such a movement and the development of a new drug that offers methadone's unique advantages but that will have none of its historical baggage. Worldwide, conditions are right for the emergence of a medication-assisted recovery advocacy movement.

Stephen Bamber: The field has recently, and tragically lost Lisa-Mojer Torres, with whom you coauthored Recovery Oriented Methadone Maintenance. It must have been particularly sad news for you, having recently worked with her on this volume. In what ways has Lisa influenced your thinking, and what do you think her legacy is, both to the recovery movement and the wider drug and alcohol treatment field?

William White: Lisa's death from a long-fought battle with ovarian cancer was a great blow to all of us in the U.S. recovery advocacy movement and to me personally. I would not have had the courage or the credibility to take on the issue of methadone-assisted treatment and recovery without her as a collaborator. The list of what Lisa did for the recovery movement is a very long one, but what she did that no one else before her had done was step forward professionally and publicly and put a face and voice on methadone—a beautiful face and a powerful voice. When she stood as a woman, a mother and a civil rights attorney and told her recovery story and the positive role methadone played in her recovery, her very presence challenged every stereotype that has ever existed about methadone and the methadone patient. I had done a lot homework that had shifted how I THOUGHT about methadone, but Lisa was the person who changed how I FELT about methadone in my gut. Here was a woman that had so many qualities all of us in recovery aspire to:

sobriety, integrity, honesty, humility, tolerance, service to others. Her story was lucid and emotionally riveting, and she was on METHADONE! No one could walk away from her and think about methadone the same. And what was most important was her acknowledgement that she was just the tip of the iceberg of those who remained hidden because of the stigma attached to this medication. She was a force to be reckoned with. We need Lisas in every community.

Stephen Bamber: I often get the impression that here in the UK we are re-tracing some of the steps the recovery movement in the US has already taken. What advice would you give those in the UK who are trying to establish a truly inclusive culture of recovery? In its journey of formation, are there any mistakes the US recovery movement has made with respect to methadone maintenance that could be avoided by UK recovery advocates as they negotiate the boundaries of their interest?

William White: In our own recoveries, each of us found truths—some personally unique and others shared with many—that we attribute today as the source of our recovery experience, but it is danger when we elevate our personal truth to the status of THE truth. We are a people prone to excess and that excess needs to be tempered with humility and tolerance and a true sense of celebration for all recoveries—no matter how markedly they differ from our own. What we have tried to do, not always successfully, is cultivate these key recovery values (humility, tolerance, gratitude and celebration) into the larger recovery advocacy movement. I think the lesson we learned is that we all have to become students of recovery. There are no teachers in this movement, only students.

The tendency of any stigmatized group is for its members to socially isolate themselves. I think one of the mistakes that can be made is that we spend too much time talking with each other about changing attitudes of those outside our circle and fighting with each other about how best to do that while spending far too little time communicating with people outside that circle. The first challenge in confronting community stigma, for example, is confronting and escaping that propensity for isolation and our propensity to pick fights inside the circle so that we don't have to face the more formidable challenges outside. The bottom line is that we can't change attitudes of communities if we don't fully enter the life of those communities. And the first challenge to entering those communities is confronting internalized stigma inside our own selves, our organizations and within our movement - purging the shame that tells us we are not worthy of leaving our closed circles. We can hardly expect communities to accept us when we have not yet accepted ourselves and each other. I think that acceptance for self and for each other comes through the grace of sharing our stories - first with each other and then with the world.



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: Bamber, S. & White, W. (2011). Inside the recovery revolution. Posted at **www.williamwhitepapers.com**

Inside the Recovery Revolution

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Introduction

***Stephen Bamber**:* The UK drug and alcohol treatment field has gone through a dramatic Recovery Revolution over the past couple of years – perhaps as extensive and enduring as the one that disrupted the mental health field in previous decades. Recovery-orientated thinking has penetrated the spheres of policy, practice and research and we have observed the inception and growth of a vibrant, colourful and heterogeneous array of grass-roots activity throughout the UK.

Although recovery discourse is still emerging from its embryonic phase and the boundaries have yet to be fully negotiated, acknowledged and accepted by all stakeholders I have been delighted (and privileged) to witness practitioners and Service Users alike finding renewed enthusiasm for their work as they undertake the sometimes difficult transition to recovery management modalities.

Recovery is being celebrated in all of its Technicolor manifestations. Significantly, services and clients are beginning to work together to authentically co-produce a new generation of recoverees. Our collective understanding of recovery will inflate as these individuals advance along their personal journeys in coming years. They will be supported by authentic cultures of recovery and recovery communities that are beginning to prosper outside of traditional treatment settings (in spaces previously occupied solely by established mutual aid groups and a smattering of pioneering peer-support initiatives).

Catalysed by the energy and enthusiasm of our homegrown recovery champions, networks of individuals are coming together and reforming a landscape whose topology was previously determined by a staid and inelastic ensemble of statutory organisations, professionals, institutions and voluntary bodies. Recovery knowledge was determined, dispersed and guarded by this powerful but arguably insufficient miscellany of entities. Other sources of knowledge exist – enfolded in the narratives of those in recovery themselves but are only just beginning to appear on the horizon of our shared understanding.

Revolutions require scrutiny: we should not blindly accept any new set of

propositions without testing them in the hotbed of our collective rationality. Bill, given the recent recovery revolution in the UK it is my hope that we can use this Dialogue to explore some infrequently examined dimensions of the emergence of recovery advocacy movements in more depth – ethics, leadership, transition, roles and responsibilities and so forth.

William White: I have followed with great excitement the rise of the UK recovery movement and look forward to offering what reflections I can on the nature of such movements. I am humbled every day by the complex questions arising within these new grassroots recovery advocacy organizations.

Stephen Bamber*:* You have depicted what is going on across communities of recovery worldwide as a recovery revolution. Is this a rhetorical device or is there a deeper meaning behind your use of this phrase?

William White*:* I use the term revolution to convey that what is unfolding within communities of recovery is without historical precedent. There is a long and rich history of recovery mutual aid societies, but only recently have we seen members drawn from these traditionally closed and competing societies standing side by side and seeing themselves as a singular community—a people. Pathology (addiction focus) and intervention (treatment focus) paradigms have long dominated the alcohol and drug problems arenas, but only recently is recovery emerging as a central organizing paradigm. This shift is more than a superficial play of words and ideas—a flavor of the month. If successful, it will transform everything it touches—including national policy and nearly every aspect of the design and delivery of addiction treatment.

Historically, responses to addiction at a personal level have been divided into recovery mutual aid societies on the one hand and professional treatment on the other. In addition to expanding and transforming both of these entities, the recovery revolution is spawning new social institutions that do not fit into either the recovery mutual aid or professional treatment categories. This shift is moving beyond support for personal recovery initiation and maintenance to first build a world in which recovery can flourish—recovery residences, recovery industries, recovery schools, recovery ministries, recovery community centers, recovery sports clubs, recovery cafes and the like—and then creating rich local cultures of recovery that are spawning new recovery-linked ideas, language, literature, art, music, service roles and rituals.

For the first time, recovering people and their families are breaking silence and stepping forward in large numbers as an organized group to put a face and voice on recovery. They are awakening culturally and politically through new recovery advocacy organizations and public recovery celebration events. What is being called for is not just adding recovery supports to existing treatment systems but a transformation of addiction treatment as we know it and a transformation of the larger communities in which successful recovery must be inevitably nested.

Embracing recovery as an organizing paradigm, nesting personal recovery within the larger rubric of community recovery and the new methods being proposed to achieve these goals do constitute a revolutionary leap within the history of addiction treatment and recovery. For treatment systems, this requires a fundamental realignment of values, relationships and service practices.

Stephen Bamber*:* Recovery advocacy is a new idea here in the UK. One of the things that concerns me is whether we have sufficiently visible (and conceptual) separation between the various groups you indicate. Are you able to briefly outline the fundamental ideological and material differences between mutual aid groups, treatment services and advocacy groups?

William White*:* The core ideas of the new movement are focused not on the nature of addiction, nor on the need for professional treatment or the value of particular types of

treatment. They instead focus on the reality of recovery, the varieties (pathways, styles and stages) of recovery experience, the role of community in long-term recovery and the fruits of recovery for individuals, families and communities. The core strategies include consciousness-raising and leadership development within the recovery community, support for new recovery community organizations, recovery-focused public and professional education, recovery-focused political advocacy, peer-based recovery support services and the sponsorship of recovery celebration events.

***Stephen Bamber**:* This focus does distinguish these groups from traditional recovery support societies.

***William White**:* Yes, they are complimentary, yet have quite distinct roles. Recovery advocacy is about giving voice to the voiceless and offering real faces as an alternative to the demonized images that have long been associated with alcohol and other drug problems. It is about building a base of influence for people who have been historically marginalized. It is about taking the strength of recovery communities that has long existed for mutual support and extending that power into an instrument for recovery-enhancing social change. But, importantly, it is doing this in a way that is respectful of the autonomy and traditions of traditional recovery mutual aid fellowships. This movement does NOT have an agenda of changing AA, NA, SMART Recovery or other recovery mutual aid societies by involving them in political and cultural mobilization activities around the recovery issue, but individual members form these societies are choosing to be part of this movement–as individuals and not as representatives of such groups.

If you think about individuals in recovery as a group of people with a common history, a distinct culture and a linked destiny, then you can look beyond addiction and recovery as a personal story and begin to see a larger story of people becoming aware of their status as “a people” and joining together for common cause. Where AA and other recovery mutual aid groups seek to reshape the personal story, the new recovery advocacy movement seeks to reshape the collective story. The former seeks to change the individual; the latter seeks to change the world.

***Stephen Bamber**:* Elaborate on this distinction.

***William White**:* Let’s take the issue of national of local forces that promote excessive AOD use. These include predatory illicit drug markets, unscrupulous elements of the pharmaceutical industry and the enormously powerful alcohol and tobacco industries. I’m talking about excessive drug availability, unchecked and medically unwarranted prescribing of psychoactive drugs and alcohol products and advertising aimed at children. If you are a recovery mutual aid fellowship like AA or NA or SMART Recovery, these are not your issues, because your focus is on initiating and sustaining recovery as a personal journey regardless of the environmental circumstances. You’re not trying to change the world, only create a way for people to recover within it. But if you are a recovery advocacy organization, any condition in the environment that contributes to addiction and inhibits or undermines recovery is your issue. Recovery fellowships are at great risk of getting diverted from their primary mission when they get caught up in such controversial “outside issues” and when they take on the political power of the licit and illicit drug industries or others whose interests are threatened by a strong recovery advocacy movement.

So what precise aspects of the world are recovery advocacy movements seeking to change? Put simply, we are seeking to change ideas, words and images through which AOD problems are expressed. We want to change how people are perceived who have or who once had but no longer have these problems. We want policies and programs that enhance resistance to AOD problems and provide support for long-term recovery from these problems and their effects on individuals, families,

neighborhoods and communities. We want fully developed cultures of recovery in communities throughout the world that celebrate the recovery experience and give back to those communities through recovery-focused service work.

Roots of Recovery Advocacy Movements

***Stephen Bamber**:* It strikes me there needs to be a particular kind of personal, social, and cultural milieu in which recovery advocacy movements can emerge, flourish and grow. Can you outline these conditions in more detail?

***William White**:* Like personal recovery, these movements spring from a synergy of pain and hope. The pain often comes from oppressive conditions affecting both those still in the life and those in recovery. In the case of the U.S., those conditions included the restigmatization, demedicalization and recriminalization of addiction on the heels of the cocaine surge of the 1980s and a parallel cultural backlash against recovery as a brief pop phenomenon. It also came from a growing sense that the ever-growing U.S. treatment industry had lost its way—had become disconnected from the larger and more enduring process of addiction recovery. People continued to recover, but the silence about these external social conditions was becoming suffocating by the mid-1990s. What started as personal conversations around the country evolved into an emerging movement by 2000.

Something had to happen. You can reach a point individually and collectively where continued silence becomes an act of spiritual suicide. You can reach a point as a people where you must speak or never again be able to look each other in the eyes. You can reach a point personally where you must speak or never be able to look into your own eyes without seeing the mask of an impostor. Pain can create such a collective/personal crisis, but only hope can turn it into a movement.

***Stephen Bamber**:* What was that source of hope in the U.S. and is it in any way related to the earlier emergence of the mental health recovery movement and its associated advocacy organisations?

***William White**:* The mental health recovery movement did not exert a significant influence on the new addiction recovery advocacy movement in the U.S. because there has until recently been a great deal of social and cultural separation between these two worlds. The spark for us was reaching a critical mass of people in addiction recovery who felt that the guiding visions of past generations of recovery advocates had been lost and that we had a duty to speak out not just as individuals but as a community. By speaking, I am not referring to the kind of emotional hemophilia that is in vogue in confessional writing and television exposés. I'm not talking about gushing the details of our past lives in public forums—details that offer great drama but offer little personal or policy guidance. And, most importantly, I am not talking about isolated individuals doing such speaking; I'm talking about thousands of people standing in unison to speak.

I'm talking about the act of declaring one's status as a person in recovery in appropriate contexts and at appropriate times. I'm talking about proclaiming that recovery is both possible and a living reality for millions of individuals and families. I'm talking about offering living proof that people who have once been part of a problem are today part of its solution. Something very magical happened when we came together, not as AA or NA or SMART Recovery or Celebrate Recovery members, but as people in recovery—something none of us had experienced within our respective personal pathways of recovery. For the first time, we looked beyond our own stories and our own pathways of recovery and began to see ourselves as a people with a unique history and a shared destiny.

What our shared stories revealed was that addiction crushed everything of value — everything we ever were or hoped to be, even the desire for life itself. And yet we learned that from these very ashes a

recovery process can rise that leads to hope and a new life. The new recovery advocacy movement that is spreading around the world is a movement built on the hope and gratitude of the resurrected. The spark for us in the U.S. and the spark that began carrying this message internationally has been the emergence of recovery carriers—people willing to use their own personal/family recovery experiences as a platform for social change.

***Stephen Bamber**:* I was twelve years in and out of treatment before I finally came face to face with somebody in long-term recovery. That was an incredibly powerful therapeutic encounter that profoundly altered my approach to my own recovery. I now had a solid foundation on which to build – hope rendered visible. Would you say that hope creates a shared vision of what could be? Is it possible to manufacture hope, or generate it systematically?

***William White**:* I think recovery advocacy movements start with conversations from which rise both collective hope and a shared vision of how the doorway of entry into recovery could be widened. The vision must captivate and elevate, but it must also contain elements that are attainable in the short run. Movements feed on small successes that raise the possibility of big successes. One of my favorite verses from the Bible is, "Where there is no vision, the people perish," but a movement can exhaust itself with a vision disconnected from the realities of the movement's resources. "I have a dream" speeches are only as effective as the plans and programs that follow. The challenge of making a movement work "on the ground" is to chart a course between the dreamers and the doomsayers. Great achievements and great defeats produce equal threats to the future of a movement because they make it seem like everything is possible or that nothing is possible.

***Stephen Bamber**:* What distinguishes those movements that flourish and grow and those that whither away?

***William White**:* I'm not sure that we know. Organizing across communities of recovery is not easy. We are a people who struggle to fit in—with other people and even into our own skins. Organizing recovering people is like trying to herd cats or snakes. We are not a very herdable bunch, and we are prone to strike at each other when provoked.

It takes a special set of circumstances for these movements to fully launch and, as you suggest—and like recovery itself, success is often preceded by many false starts. I wish there was a formula to this, but there really is something magical about it all—the right people rising together at just the right moment. It is amazing to see such cultural connection arise from so many histories of personal disconnection. I am still in awe of it all. The key seems to be the emergence of bridge people—those who hold membership in and command respect from multiple groups. Without those people leading the way toward a larger identity, all you have is warring personalities, groups and ideologies. For a movement to flourish, selected members of closed groups must rise above their sectarian identities and forge a broader understanding of WE—a broader circle of identification of my people.

***Stephen Bamber**:* "A broader circle of identification of my people" – this statement seems to suggest that membership of such groups is important in terms of self-identification and self-transformation. Is there something formative about involvement in recovery advocacy movements that relates to the recovery journey itself?

***William White**:* I think so. There are a lot of people who resolve substance use disorders without a transformation in personal identity. This is revealed through community studies reporting a significant population of people who once met criteria for alcohol or drug dependence but have not met such criteria in the past year. Many of these individuals do not self-identify as having been addicted or see themselves today as a person in recovery. But for the most severe and complex substance use disorders, I do think

this identity transformation is often an integral part of the recovery process. This is evident in an almost universal story style across secular, spiritual and religious pathways of recovery. We describe what things used to be like (addiction career), what happened (transformation process) and what things are like now (recovery career). Story reconstruction, storytelling and identifying with the stories of others are the rituals of identity transformation within this more self-conscious recovery process.

Stephen Bamber: Would you say that recovery and recovery advocacy has successfully penetrated all minority and marginalized communities in the US? I am mindful of the situation in the UK (where this is most definitely not the case)

William White*:* It is a mixed picture. We have strong representation of African Americans in recovery and organizations that serve predominately African American communities within the national recovery advocacy movement in the U.S. Native American leaders and organizations also have been included from the beginning and have exerted a powerful influence on the overall movement, particular in the person of Don Coyhis and White Bison, Inc. While involvement of Hispanic and Asian-American organizations is increasing, we still have a long way to go to fully involve these communities. Members of the LGBT community have also had strong representation in the recovery advocacy movement since its inception. There continues to be a struggle at local levels to achieve representation by members of historically marginalized communities.

Stephen Bamber*:* What about countries in which there is no evidence of such a movement yet?

William White*:* To get from I to WE—the emergence of a collective consciousness and mutual commitment takes a while and the process can include many aborted efforts. There are many countries around the world that have few if any addiction recovery support groups, few if any treatment resources, and no visible recovery support or advocacy movement. But all countries have gone through such a stage. The sequence is usually conversations, mobilization, support groups and then advocacy groups, and that needed sequence can unfold over years or over decades. What a visible international recovery advocacy movement will do is dramatically speed movement through these stages through the instantaneous exchange of information and support that the Internet provides.

Stephen Bamber*:* Bruce Alexander eloquently describes the globalization of addiction. Do you think we are at a stage where we can talk about a corollary 'globalization of recovery'?

William White*:* I do think we are approaching that stage. The level of international contact between recovery advocates has never been greater, and recovery movements around the world seem concerned about reversing the loss of community that Alexander mourns. I suspect we will see this blossom in the next decade. Faces and Voices of Recovery in the U.S. has launched an international section to its website as a way to provide connective tissue between people and organizations in countries where recovery advocacy activities are increasing.

Stephen Bamber*:* The by-products of globalization, such as the explosive growth in electronic social media will catalyze the growth of these movements. Will there not be a contiguous homogenization of recovery advocacy and is this a good or bad thing?

William White*:* The growing presence of recovery advocacy via electronic media could produce such homogenization, but I suspect we will continue to see broad cultural adaptations of both the goals and strategies of worldwide recovery advocacy movements in the coming decades. There is a tendency in the US to see ourselves as a teacher rather than a student in this

process—one of our worst character defects, but I think in the long run the US has much to learn from what is unfolding in the UK and in other countries.

***Stephen Bamber**:* On a side note – are the techniques and practices of recovery advocacy specific to the cultural milieu of global neoliberalism? Will communities who are marginalized by these global forces be able to spawn effective recovery advocacy movements?

***William White**:* We hope the new international section of the Faces and Voices of Recovery website will provide some answers to this precise question. At present, we really don't know. I suspect that we will see wondrous varieties and styles of recovery advocacy, and we may well find contexts in which recovery movements are not yet possible. Even the term recovery may be recast and redefined in different cultural contexts. Recovery, sobriety, and Wellbriety have served as central organizing metaphors in the U.S., but there is no assurance these terms will have similar salience in other cultures, although the spread of AA and NA internationally suggests wide resonance of these concepts. In the West (US and UK), we have public advocacy and mass recovery celebration events. It is not clear that recovery advocacy will take such forms in South America, Europe, Asia and Africa. And these movements may not unfold contemporaneously. Each may need to unfold in its own time. What most amazes me is the great variety of venues through which recovery advocacy is being expressed internationally: art, literature, music, theatre, comedy, business, media, sport and religious ministries, to name just a few. I am the ultimate student of these forms and can't wait to see what the future holds. I have written a great deal about the culture of recovery, but I think this culture will reach stages of development in the future that are now unfathomable.

Movement Leadership

***Stephen Bamber**:* What guidance would you have for persons who would seek or who would be asked to assume leadership positions within recovery advocacy organizations?

***William White**:* Such roles can bring deep fulfillment, but they also come with hidden risks. Vulnerability may be an aspect of all leadership roles, but this may be particularly pronounced in organizations organized by and on behalf of persons from historically disempowered groups. I recall one of my friends once noting of the civil rights organizations in which he was involved, "We don't elect leaders; we elect victims." He was referring to the tendency of these organizations to scapegoat their leaders while the leaders are living only to later reify them–often after their deaths. Within any stigmatized group, we want our leaders to excel—to model the best of what we can be. And yet the shadows of shame and inferiority buried inside us get projected onto our leaders in the form of doubt, criticism and attack.

When the recovery advocacy movement in the U.S. first came of age in the U.S., our first national leaders brought recovery credentials, but many had short life expectancies in their leadership roles. In retrospect, I'm not sure anyone in recovery from any constituency group could have commanded broad enough respect and a broad enough range of skills to have survived at a national leadership level. When Pat Taylor assumed leadership of Faces and Voices of Recovery, there were initial mumblings from the grassroots that she was not a person in recovery, but she was the perfect choice at that time to stand without historical baggage between all the constituency groups and bring them all to the table. Yes, she brought great skills and energy to this role, but she succeeded also because we did not need to act out our own damaged self-esteem at her expense. I'm not suggesting we avoid choosing leaders in recovery, but I am suggesting that all our leaders need protection from forces within

the movement as well as from the more visible forces of resistance from outside the movement.

Stephen Bamber: This raises a broader question about the roles people without personal or family recovery experience can play in the movement.

William White*:* There is a long history of the contributions of people not in recovery to recovery mutual aid societies and recovery advocacy movements similar to the supportive roles whites played in the American civil rights movement. What would have been the fate of AA without people like Charles Towns, Dr. William Silkworth, Reverend Sam Shoemaker, Henrietta Seiberling, Sister Ignatia, Dr. Harry Tiebout, Jack Alexander, Father Edward Dowling, John Rockefeller, Willard Richardson, and Frank Amos, to name just a few? AA historian Ernie Kurtz once noted the following about these individuals.

They were not alcoholic, but they did all have something in common: each, in his or her own way, had experienced tragedy in their lives. They had all known kenosis; they had been emptied out; they had hit bottom....whatever vocabulary you want. They had stared into the abyss. They had lived through a dark night of the soul. Each had encountered and survived tragedy.

What Ernie is suggesting here is very important. What is needed to connect to this movement is not a past status of addiction nor a particular set of professional credentials but experiences that allow a person to relate to recovering people from a position of humility and emotional authenticity and to enter into these relationships from a position of moral equality. It is also important to acknowledge that family members have been fully welcomed into the heart of this movement, including in leadership roles, and friends and allies are playing important roles in this movement.

WE Movements versus I Movements

Stephen Bamber*:* There would seem to be considerable differences between advocacy organizations that have broad and rotating leaders versus those relying on a single charismatic leader?

William White*:* Yes. Who in recovery has not had messianic aspirations of saving oneself and then saving the world? But the last thing a recovery advocacy movement needs is a messiah. Few people in recovery could survive the pressure of such a role, and I don't know of a single successful movement that relied on a single charismatic leader or even a small cadre of such leaders. The long-term strength of these movements comes from what we do together. I-movements rise and fall while WE-movements endure. That's one of the many lessons recovery advocacy movements should learn from AA's survival as a recovery mutual aid society.

There is a new age cultural shtick suggesting that we must each find our own song to sing. That's easy for people in recovery. We have always felt pathologically unique and socially disconnected—always sung our own song, usually out of harmony with everyone around us. A movement of such emotional and relational iconoclasts, if it ever could be called a movement, would sound more like a Tower of Babel than a choir. The question for us as a people is not. "Can we each find our own personal song?" It is, "Can we find a place and a song that we can sing with others in harmony?" And this is not just an issue of whether a movement can develop a central message and stay on message. It is about how to protect those who choose to participate in the movement. It is the awareness that standing by the hundreds and thousands reduces the enormous vulnerability that comes from standing in isolation to confront stigma and its multiple manifestations.

Put simply, it is not safe for us to stand along. Attention can make the most stable recovery tremble. The glare of the camera and the beckoning microphone can be as intoxicating as any drug. Like Icarus flying

too close to the sun, we are doomed in the face of such self-absorption—whether from overwhelming feelings of unworthiness or, perhaps worse, from the feeling that we are the most worthy. It is only when we speak from a position of WE that safety and protection of the larger cause is assured. When asked, "Who is your leader?" we should declare that we are without leaders or that we are all leaders. The media wants a hero they can deify today and castigate tomorrow. The latter can be prevented only by preventing the former. Enemies of the movement want individual targets. Such targets must be either denied or carefully protected.

***Stephen Bamber**:* What about those who do possess charismatic gifts –is it possible for these individuals to find a place for themselves in a WE organization or are they forever doomed to be solitary "I"'s. Furthermore, how do you manage such individuals (or support these individuals to self-manage themselves effectively?). People with charisma tend to naturally assume leadership roles and responsibilities– the group allows them to take that role. Isn't there a tension here?

***William White**:* Charisma is a blessing and a curse to recovery mutual aid and recovery advocacy movements. It is something of a paradox that such movements often cannot survive their infancy without charismatic leaders, but cannot reach maturity without transcending charismatic styles of leadership. Charisma creates what might be called the "high priest" role, its inner circle and the centralization of power that is its inevitable accompaniment. As power and control emerge as central themes in the life of the organization, there are inevitably plots, conspiracies, uprising, schisms, and purges. Even when the high priest is overthrown in such circumstances, the coup leader often simply assumes the high priest role and the process continues.

Only AA's Traditions allowed it to escape this fate, but even in AA these cycles are sometime recapitulated at the local group level. AA is one of the most decentralized organizations in history, but even AA had to struggle with the question of whether it could survive the passing of its founders. There is always ambivalence about such central figures. Bill W. and Dr. Bob have been reified within AA since their deaths as has Jimmy K. in NA, but this status masks the bitter criticism they each faced within the fellowships when they were alive. As a group, we both need the strong charismatic figure while at the same time we hate ourselves for that need. Escaping that dilemma requires the central task of growing up and accepting responsibility for the fate of ourselves and our organization. Both recovery mutual aid societies and recovery advocacy organizations/movements eventually need to come of age through such a maturation process.

***Stephen Bamber**:* What about the challenges of transitions in leadership?

***William White**:* Perhaps the greatest of such challenges is the transition in leadership between the founders of recovery advocacy organizations and the second generation. That is always a litmus test of viability, just as it is in recovery mutual aid societies. Organizations and larger movements that are successful find ways to decentralize leadership through structures that provide for leadership development and rituals that facilitate regular succession.

Even under the best circumstances, these transitions can be difficult for the organization and for the individuals involved. We have a tendency toward strong, charismatic leaders because it is so difficult to launch and sustain recovery advocacy organizations. Once successful, we then have to figure out how to live with and without such leaders. And we have to manage the more common transitions of people entering and leaving participation in the movement. We need to build in permissions, procedures and processes for people to leave active participation in the movement.

The movement itself is best conceptualized as a marathon run as a relay—people engaging and disengaging as

needed over a prolonged period of time. Many people will come and go or return at particular times in the life of the movement, while others will be part of the daily struggles of the movement for the duration. That's just the way social movements are; this is not to say one style is superior to another. I am a great admirer of endurance and tenacity, but movements also need those who help in short bursts.

***Stephen Bamber**:* It is inevitable that some leaders will be self-appointed –particularly in nascent movements as they cross the threshold of emergence. Furthermore, it is difficult to establish rotating leadership in organizations who in the early stages of their formation. How long should such leaders remain in situ? Is there any guidance you can offer to help those involved in such groups.

***William White**:* I'm not sure we have a firm answer to that question yet. I think the principle is as follows: The longer the intellectual, emotional and social life of the movement is centered on a charismatic leader, the less the long-term viability of the organization or movement. But you are right, without a charismatic figure or a cohesive leadership core, movements would not get fully launched and reach a stage of initial sustainability. You can't move beyond such figures until a vision, values and rituals are forged that can sustain the group and its replication and dispersion by cell division in the absence of the leader. That's also why movement literature is so important.

The alternatives to cult-like leaders require concerted leadership development efforts and the progressive decentralization of decision-making throughout the organization. AA and NA have done this through the framework of their traditions and service structures. Now this does not mean that we have to challenge and extrude our charismatic figures to achieve maturity, but it does mean that we have to help such figures redefine their roles and relationships—in short, to join the movement as members. When that doesn't happen, the organization/movement moves towards incestuous closure and the risk of eventual implosion (See Janzen's book, The Rise and Fall of Synanon).

Radical Recovery

***Stephen Bamber**:* You have written about a style of radical recovery? Is that an aspirational model for everyone involved in recovery advocacy?

***William White**:* I don't think that is a style for everyone. Many will want to keep their involvement focused on a personal level of recovery support. But we need voices within the movement to remind us, sometime in indelicate language, that the bodies and souls of the addicted feed multi-billion dollar industrial economies. A radicalized recovery—even a culturally and politically conscious recovery—recognizes that recovery is a political as well as personal act. A day may come when recovery will be initiated as an act of cultural protest—a strike through which we refuse to feed licit and illicit drug industries, the prison industrial complex, predatory treatment institutions (those that care more about corporate profit than patient progress) and all their sub-industries. We need people to remind us that addiction is a story of personal vulnerability, but that it is at the same time a story of collective vulnerability—vulnerability rooted in particular historical, social, economic and political circumstances. We need people who remind us that addiction is also a manifestation of historical trauma, class warfare and community degeneration.

We have to ask ourselves, "Who profits from excessive AOD use and the demonization of AOD problems? The politicians, the press, the multiple institutions that have been granted partial ownership of these problems reap such benefits. There are also the AOD industries who profit from the portrayal of the source of AOD problems as residing with the personal pathology of a deviant minority rather than with their products and their marketing schemes. These are powerful forces to challenge, and we should never forget that in terms of the campaigns we choose to wage, nor should

we forget this in terms of our organizational or personal safety. If we as a movement confront the political manipulation of the public images of addiction, if we challenge the safety of products produced by billion-dollar industries, if we suggest higher taxation of AOD industries to pay for the casualties that are a byproduct of their profits, if we suggest that prisons are serving as concentration camps for sick people more in need of medical care than paramilitary control, and if we demand that treatment institutions be portals of exit into sustainable recovery rather than revolving doors for brief respite within prolonged addiction careers; then we can expect pushback of enormous proportions. We must build a power base to take on such battles and choose those battles carefully. Misjudgments in this area can have dire organizational and personal consequences.

***Stephen Bamber**:* You referenced prisons. Do you feel prisons will become an incubation chamber for radical recovery?

***William White**:* I do. I think such a style of radicalized recovery will rise within the prisons systems and then move into communities across the world. That seems a strange prediction given that on their surface prisons are such an inhospitable environment for recovery, or for that matter, for any social movement. But I think prophets will rise within these environments who will articulate a new motivation for recovery and a new style of living in recovery that will blend personal transformation with cultural and political activism. There may be people reading these words at this moment who will lead this movement. I suspect that movement will start in the U.S. because of the frenzy with which we have tried to incarcerate our way out of the addiction problem.

Image Management and the Media

***Stephen Bamber**:* One of the goals of the recovery advocacy movement is the authentic portrayal of the recovery experience. What challenges do we face in this process? Isn't there a danger of creating a master narrative that excludes those who do not or cannot self-identify in such a way?

William White: We must contend with twin dangers. First is the saturated press coverage of iconic deaths and other dramatizations of addiction. Second is the repeated portrayal of people representing recovery who know little if anything about it–celebrities recycling in and out of "rehab" following their latest crash and burn experiences, or persons freshly out of rehab still in the throes of the recovery honeymoon who want to convert the world. The resulting public image is one of recovery pessimism and the image of recovery as someone hours or days sober or not sober at all who is self-destructive, self-absorbed and pleading to escape the consequences of their latest indiscretions—in short, someone who got caught! Such an image conveys a definition of recovery as someone who, at best, is trying to stop their drug use or, at worst, someone who is using a feint towards recovery as a manipulative gambit.

Another factor contributing to a distorted image of recovery is that the public faces and voices of recovery tend to be over-represented by those of us who have become a "professional ex"—persons in recovery employed in the AOD problems arena. This may inadvertently convey that recovery is only possible living within this restricted milieu or that recovery is simply a jobs program for people who can function in no other setting. There is no recovery movement as long as the faces and voices of recovery are those in paid roles within the AOD problems arena. We become a movement when we stand not as addiction counselors or paid educators, but as people in recovery who are business, political and religious leaders; physicians and pilots; students and construction workers; actors and musicians; teachers and computer techs; nurses and authors; and who stand representing a rainbow of ethnic groups, political parties and religious faiths. That's when stereotypes will shatter and stigma will die of exposure.

Now the first inclination to counter these stereotypes is to march several thousand of us into the streets to proclaim that we have not used alcohol or drugs for years and that our lives in recovery could not be more perfect. This is the recovery version of The Stepford Wives movie, for those who remember it—a compliant, giddy happiness that mistakenly conveys that the achievement of recovery is an exhilarating leap into "and he/she lived happily ever after." As a movement, it is tempting to march into public our prettiest, smartest, most articulate, least threatening members and fill the media cameras with smiles and recovery slogans, but that is a temptation we must resist or quickly escape.

And it is easy for us to get seduced by this image at a personal level through misguided efforts in recovery to become the perfect person, to create the perfect life and to project this perfect image of recovery to others. This is a poor choice personally because it creates an image none of us can live up to, and it also invites attack from those who refuse to believe that intelligence, attractiveness, industriousness and service to community cannot co-exist with addiction recovery. Presented with such images of perfection, people will seek to revoke either our addiction stories or recovery stories to keep their own stereotypes and their view of themselves intact. These stereotypes must be shattered by the authentic, but imperfect stories of the daily lives of thousands of people in recovery.

The alternative to the "recovery is a sham/hustle" and "recovery is a panacea for all life's problems" is an authentic portrayal of the complexity, intensity and, at times, emotional rawness of recovery. Recovery requires climbing through a mountain of garbage before we become as clean inside as we appear outside. Recovery bears wonderful fruit, but it is also about struggle and suffering because life is about struggle and suffering. Recovery is about imperfection and brokenness because all humans are imperfect and broken—some of us more than others. Recovery is about escaping secrets because all humans have secrets that we spend a good deal of our lives running from.

So we need recovery stories that tell the story of whole people and the whole recovery experience. We need people who can say "Recovery is my most sacred possession" and also say there are days when "recovery sucks"—that it's complex and confusing and uncomfortable and emotionally messy—and that yes it is all worth it!" What we need are stories of authentic experience rather than stories whose intent is to sell something. Above all we must be careful in not replacing alcoholic and dope fiend caricatures with equally stereotyped caricatures portraying all people in recovery as deliriously happy, spiritually enlightened super-citizens. And to do that we must understand the press in all its forms.

The primary function of the press is not truth, justice or social contribution; it is the sale of products which involves an ever-escalating competition for the public's attention. Every day the press creates heroes and destroys heroes; it elevates causes and obliterates causes all for one purpose: attention. So the challenge we face is to use this institution at the same time it will seek to use us, while avoiding the highs and lows of this perpetual drama as best we can. The problem in using the press as a vehicle of recovery education is that long-term recovery progressively eliminates what the media thrives on—drama and crisis.

Stephen Bamber: What do you see as the value of larger recovery celebration events?

William White*:* At a personal level, they help purge the shame that festers or, at best, lingers as a deep stain on those of us who have experienced addiction. Shame is about the loss of face—the sense that we have lost our right to be seen and heard not because of what we have done or failed to do but because of who we are. Faces and Voices of Recovery was the perfect name for the organization that would represent us in the U.S. because, at its most fundamental level, this movement is about the restoration of face and voice and the use of our publicly

disclosed stories as a catalyst for social change.

At a cultural level, these events make recovery and its varieties and styles visible, acceptable and even heroic. It is amazing to see how people in recovery respond the first time they march in public with thousands of other people in recovery. We have for many years had an annual event called America Honors Recovery at which we bestow awards on individuals and organizations who have helped shape the future of recovery in the United States. I think such events are very important. I know some people who are nominated get squeamish about such attention, but I think to refuse such an honor is to disrespect the community which bestows it. I nominate people every year for this award and feel it is an important ritual through which we pay tribute to those who are truly making a difference with their service work.

***Stephen Bamber**:* Not everyone wants to publicly celebrate his or her recovery – don't some people want to become socially "invisible" and free to live their lives without attracting attention? I am particularly mindful of those in medication-assisted recovery who face prodigious barriers to social re/integration. Is there a place for such people in recovery advocacy movements and if so, what might that be?

***William White**:* Yes, a large number of people are involved in recovery advocacy quietly and invisibly. The call for a vanguard of people in recovery to put a public face and voice on recovery is not a call for all people in recovery to serve in such public roles. It is a call to those who are temperamentally suited for such a role and whose present life circumstances permit such a role without harm to themselves or their families. For those who prefer to, or by necessity must, avoid public participation, there are many ways they can offer support. Many work behind the scenes in support of advocacy activities, offering time and contributing financial support—neither wanting nor receiving public acknowledgement for that support. There are all manner of styles of participation in recovery advocacy. All are needed and all styles of support should be respected.

Role of Government

***Stephen Bamber**:* What is the role, if any, of government in recovery advocacy movements?

***William White**:* We are seeing governments begin to embrace recovery as a new organizing paradigm for managing severe alcohol and other drug problems. This marks a shift in focus from allocating resources to study the problem or intervene in the problem to the actual solutions to the problem, e.g., resilience, resistance and recovery. Governments are exercising this shift in thinking in three primary areas: policy, funding, and regulatory guidelines and monitoring.

In the U.S., our national Center for Substance Abuse Treatment (CSAT) played several important roles in the recovery advocacy movement. In 1998, CSAT began providing seed money to stimulate the development of grassroots addiction recovery advocacy organizations. That helped stimulate local organizations but it also created venues to bring these local organizations together for the first time at national meetings. That provided tremendous impetus in creating those cross regional conversations that were so important to the launch of a national movement. CSAT's Recovery Community Support Program was an important cauldron for development of the movement's kinetic ideas—ideas that would later stir communities to action across the country. CSAT would also came to play important roles in the elevation of national recovery month activities, in elevating recovery as an organizing concept for addiction treatment, and in hosting a series of recovery summits. Sometimes governments can help in the simplest of ways. When we planned the historic 2001 Recovery Summit in St. Paul, Minnesota, we did not need money for speakers or such—we were all there as volunteers, but we did need money to pay for

advocates from around the country to get there who could not otherwise afford it. We were able to find some existing government contracts through which we could help subsidize the travel costs of many of the participants. If you look at what has flowed out of that meeting in the years since, you could build the case that those travel dollars were one of the best investments in the history of the addictions field. Contributing to getting the right people together at just the right time can reap dividends for decades to come. Governments can help most by facilitating that gathering process.

***Stephen Bamber**:* Were there any downsides to this government involvement?

***William White**:* There were lessons in the power of government money to influence a movement's direction. In 2002, political winds had shifted and CSAT was directed from the White House to stop funding advocacy activities. To salvage the RCSP, CSAT shifted its emphasis from funding advocacy activities to funding recovery support services. Like a lightning strike, the larger movement through this influence shifted in this same direction. Some organizations refused to change their mission and refused continued funding. Others shifted, but tried to find other ways to continue advocacy activities—either on a voluntary basis or through other funds. For those local organizations completely dependent on CSAT funding, many changed in what seemed like a heartbeat. It was a powerful demonstration of how a movement's focus or core activities can be shifted not based on shifting needs and priorities of people seeking or in recovery, but by external political and financial forces.

Stephen Bamber: This is interesting and important. It would be tragic if recovery advocacy became dependent on governmental funding alone. Isn't there something disempowering about this? Wouldn't this prevent the style of radical recovery you have talked about?

***William White**:* Yes, the worst thing that could happen would be a movement that through its financial dependence became a puppet whose strings were controlled by the political winds of the moment. And we flirted with such dependency in the early days of the recovery advocacy movement in the U.S. At some point, recovering people must take ownership of the financial future of the movement. Our friends and allies can help, but the central core that sustains our existence must be controlled by people in recovery.

***Stephen Bamber**:* So you're suggesting that government has the power to help and hurt recovery advocacy movements?

***William White**:* Yes, and there are more subtle forms of injury that is of concern. Let me give you one example. Many recovery community organizations had offered peer-based recovery support services through the use of volunteers before the shift in CSAT policy. With the policy shift, many began provided these services through paid roles. What that constituted was a step toward the professionalization and commercialization of the role of indigenous peer support. Some of us argued that great harm could come from this shift if it resulted in an erosion of the long-standing volunteer service ethic within communities of recovery. The jury is still our on whether this injury has occurred and is in fact occurring. The test of long-term effectiveness of the recovery advocacy peer support movement will be how much of what we are doing is sustainable without external funding. Money comes and goes. The movement must be built on a foundation of voluntary service.

Stephen Bamber: Would you say the overall influence of government funding has been one of help or harm?

William White: I think the primary influence has been one of help. What CSAT was able to do was infect national policy with recovery and the ripples of this influence extended to the White House Office of Drug Control Policy (ONDCP) and is now extending to our

addictions research institutes—the National Institute on Drug Abuse (NIDA) and the National Institute for Alcohol Abuse and Alcoholism (NIAAA). The resulting changes in policy have ripple effects far beyond what would have been otherwise possible.

Such effects were possible because of people like Dr. H. Westley Clark and Cathy Nugent at CSAT and Tom McLellan and Keith Humphreys during their time at ONDCP. We tend to think of the recovery advocates working in grassroots organizations as the tip of the spear of this movement, but there are also recovery advocates working in the belly of the administrative beasts that govern alcohol and other drug policies. I have had the pleasure of meeting Mark Gilman and others in the UK who I also see playing this kind of a role.

Stephen Bamber: Nikolas Rose talks about Citizenship being demonstrated through 'the free exercise of personal choice among a variety of marketed options'. Governmental conceptions of citizenship tend to be fairly narrow – it simply means becoming an efficient producer and consumer. Doesn't this narrow conception of citizenship marginalize a vast number of individuals who are unable to fulfill these economic obligations?

William White*:* The concern you raise is why it is very important to talk about citizenship in the context of recovery. I know there was some reaction in the UK to citizenship being included in the Betty Ford Consensus panel's definition of recovery. As I understand it, there was concern that including citizenship in the recovery definition would reduce the meaning of recovery to one of achieving economic production. We did not think of it this way in our discussions at the Consensus Panel. We saw addiction as a process of other- or self-imposed isolation from community and a process that often turned one into a parasite on the community. We used the term citizenship to convey the recovery-facilitated process through which one rejoined and contributed to the community. We saw citizenship more in terms of social inclusion and service than the act of working and paying taxes, although those activities do have meaning for many people in recovery. We also saw citizenship as a process of exercising one's regained power to make choices and to positively influence the world.

Money and Movements

Stephen Bamber*:* Let's talk more specifically about money and movements.

William White*:* Yes, I have written about how recovery advocacy movements can be harmed by too much money, too little money, ill-timed money and tainted money. There are two issues related to money and the recovery advocacy movement that currently have my attention–growing concern about recovery capitalism and the future potential of recovery philanthropy.

Stephen Bamber*:* What do you mean by recovery capitalism?

William White*:* Recovery capitalism is a term that depicts the shift from a purely volunteer social movement to a movement with financial capital and other resources. As an example, successful recovery advocacy movement will speed the rise of an elaborate culture of recovery. The question is, "Who benefits from the sale of recovery culture trappings or the jobs created in the wake of the movement?" Historically disempowered communities (e.g., Native American tribal communities) have been invaded and plundered for generations by persons claiming to help who drew resources out of those communities and left nothing in return but feelings of betrayal and abandonment. That same thing could happen to communities of recovery.

Stephen Bamber*:* How do we separate the authentic trappings of a growing recovery culture from the exploitive knock-offs and distinguish the servants from the hustlers?

William White*:* I think "group conscience" of the movement will distinguish those objects

that reflect the themes of the movement, but beyond the objects themselves are the issues of their source and the question of who benefits from their sale. Do these objects come from authentic recovery community organizations? Is the emphasis on the message or the messenger? Are the resources from this product or activity building community recovery capital or are they garnering personal gain? Do the profits from the sale of these items remain within the movement to support the continued work toward movement goals, or do they benefit private individuals or organizations whose primary missions are not those of the movement?

This is not just an issue of good people and bad people, although we must be vigilant in guarding against predatory individuals hijacking organizations or projects for their financial gain. It is more often a problem of drift—the need to constantly monitor our own thinking and our own actions. I have tried to distinguish what I do as a professional for which I am paid and what I do as a recovery advocate that I do for free as part of my service work. I do not accept royalties on the proceeds from the books I have authored/co-authored on the recovery advocacy movement; they instead have gone to support recovery advocacy organizations (e.g., Faces and Voices of Recovery; White Bison, Inc.). My general approach when I was traveling a great deal professionally was to be paid for my time and expenses to present at a professional conference and to volunteer time before or after such an event to local recovery community organizations. The care to avoid "making money off the movement" is a function of trying to practice what I preach as well as a strategy of self-protection. As I noted earlier, we have a tendency to "eat our own." I have tried to avoid being on the receiving end of that process.

There's a difference between a recovery community organization selling recovery trappings (T-shirts, books, tapes, etc.) whose profits underwrite local recovery advocacy and recovery support activities and a private vendor who chooses to exploit this personal renaissance for personal or institutional profit. In the former, resources are recycled as a continual process of recovery community development; in the latter, these products become pornographic via their lack of authenticity and their exploitive intent. Recovery capitalism within the latter tradition reduces the movement to marketing slogans and trinkets and trash. The nature of capitalism is to objectify and commercialize everything. Movements of the heart must find a way to protect the spiritual from the material—to rise above such temptations within the movement and to protect the movement from such exploitation by outside forces. We must remind ourselves that at the core of this movement is a priceless gift—recovery—that cannot be purchased. The potentially corrupting influence of money must be actively managed. AA did this by pledging itself to cultural poverty and by refusing to endorse outside products and enterprises.

***Stephen Bamber**:* Elaborate on the issue of paid roles?

***William White**:* New organizations and paid service roles are part of the process through which a successful movement becomes institutionalized—and I mean that in a positive sense of how new experiments in change become structured for greater permanency. We need to create organizational contexts and roles through which previously marginalized people have pathways to full community integration. These opportunities must be protected to prevent them from being hijacked by others. The concern when the movement garners great resources is an invasion that displaces the mass of people in recovery with people lacking experiential knowledge of recovery and without the vision of those who sacrificed themselves to create these opportunities. In the U.S., we saw this happen in the 1970s and 1980s through the professionalization of the role of addiction counselor.

***Stephen Bamber**:* And what about recovery philanthropy?

***William White**:* Effective social movements generate resources and accumulate assets—what sociologists refer to as the spoils of movement success. These resources and assets can be continually re-invested in the movement or be drained from the movement through a process of plundering and exploitation. This is a hard equation to calculate, but the general idea is that every person and organization drawing resources from the movement has a duty to give resources back to the movement whether in the form of volunteer labor or money. How much and how often is a matter of personal conscience, but the nature of such decisions will be noted by those the movement is pledged to serve and they will make judgments that distinguish the healers from the hustlers.

It is open to question whether recovery advocacy movements will ever mature to the point of financial self-sufficiency—a point where the movement is supported by people in recovery to the extent that the movement would not be dependent for its existence on external authorities. We need to support this movement with our time and talents, but we also need to support it with our wallets. We need to advocate with our money as well as our voices.

Cultural/Professional Backlash

***Stephen Bamber**:* What is the ultimate goal of recovery advocacy as a social movement?

***William White**:* The backlash has many sources. First, there is an inevitable backlash from those people and institutions threatened by the change that is being proposed. With some movements, this can be minimal because they are operating within a vacuum without strong vested interests. But that is definitely not the case with recovery advocacy movements. Push back can be expected from many of the sources we've discussed — politicians who've used the demonization of addicts for political gain, treatment industries, the criminal justice system and so forth. And backlash also comes from the movement itself. I think it was Bertrand Russell who once said that all movements go too far, and he was probably right. This may be particularly true in a movement organized by and for people with such histories of personal excess. That excess can get manifested over time in both our goals and our methods. Movements have not succeeded until they have survived such excesses and the resulting backlash and institutionalized their gains. Once those gains are in place, the most rabid change agents become conservatives desirous of protecting the new status quo they helped create.

***Stephen Bamber**:* One of the things I have noticed in the UK is a backlash from some (but by no means all) professionals traditionally involved with addiction treatment – psychologists, psychiatrists, social workers, nurses, and so on. In a well-integrated recovery-orientated treatment system professionals and their expertise will be valued as equal partners in local recovery management teams. Do you think there is a danger some professionals could be left to fix the damage inflicted by well-intentioned laypeople?

***William White**:* You've raised two issues here. First, is the professional resistance to the recovery advocacy movement's challenge to create a more recovery-focused approach to addiction treatment and to wrap treatment in a broader menu of recovery support services. Such resistance comes from many sources. There is the issue of professional defensiveness ("We're already doing that—recovery-oriented care."; "Are you saying that what we have been doing all these years is all wrong?"; "This recovery stuff is just a fad; it will fade like all the 'flavors of the month' that preceded it.") and guilt over the suggestion that treatment programs and their staff have reaped financial rewards from the constant recycling of people through treatment and that such these financial incentives have contributed to the lack of services focused on full, sustained recovery. There is fear that the

status and territory of addiction professionals is being threatened. There is concern among those who don't get this "whole recovery thing" that such trends as peer-based recovery support services are a step toward the deprofessionalization of addiction treatment, or as is sometimes crudely put to me, "dumbing down" treatment or "turning the asylum over to the inmates." Such comments reflect undertones of disrespect and contempt that have long-plagued relationships between addicted people and service professionals.

There is danger that this mix of professional resistance and anti-treatment sentiments coming from survivors of inadequate treatment could undermine the needed partnership between professional treatment services and the support services that are now rising out of the recovery community. And there are very real questions professionals are raising that have yet to be answered scientifically and experientially about the effects of recovery support services on long-term recovery outcomes, the interactive effects of those services with professional treatment, what types of people are best suited to provide recovery supports, what organizational contexts generate the best outcomes for recovery support services. Those kinds of questions should be asked and answered.

This tension is not about the question of which role is most effective in supporting recovery. It is a question of what people need at particular stages of their addiction and recovery careers. I think addiction professionals are extremely adept at helping patients stop using and achieve biopsychosocial stabilization, and I think they can be helpful later with the emotional crises, identity reconstruction and relationship repair that are at the core of the mid-stage recovery experience. What I don't think professionals are adept at is helping manage the transition between recovery initiation and recovery maintenance in the community. Failure to master that transition is what keeps people constantly recycling through treatment, and mastering that transition is often done within a community of other people in recovery who are experts, not on treatment, but living in recovery. Successful long-term recovery often involves a supporting cast of professionals, family, friends, peers in recovery and indigenous community healers. All need to be part of the recovery management team.

Secondly you have raised the issue of harm in the name of help within recovery advocacy and recovery support movements. There is a long history of harm in the name of help in the history of addiction treatment and that history could be continued in the realm of recovery support services if we are not very careful. That is why it is so important to maintain role clarity and role integrity with these recovery support roles and continually monitor their effects across diverse populations and settings. There is the need for values-based service principles, and, if not ethical guidelines, at least a consensus on the etiquette through which decision-making in the peer recovery support process should be filtered. If we don't tend to these issues, then professionals may be left to mend the damage inflicted by lay people who are well-intentioned or, in what could turn out to be the worst scenario, not so well intentioned.

***Stephen Bamber**:* How do we ensure professionals buy-in to the principles of recovery advocacy?

***William White**:* I think we have to first respect and honor the contributions professionals have made by thanking those who have played important roles in our recoveries. We need to assure professionals that our sharpest criticisms are aimed not at inadequately executed treatment protocols but at fundamental flaws in the very design of those protocols. When we focus on that, we find common ground between the best service professionals and the most adamant recovery advocates. And then we have to find forums where we can enter into partnership to participate in this redesign of addiction treatment. Everywhere I go, I find long-tenured professionals excited and re-energized by this move toward more recovery-oriented care. For many, it recaptures the very essence of what they

hoped to be able to do working within this field. Having said that, it is important to note that not all professionals will make this transition we are undergoing. Some will reject this partnership and feel that it is a breach of professional ethics/boundaries or decide that they are simply not suited for how their role will change in this new world of addiction treatment. We should thank such people for their service and bid them adieu with full knowledge that such transitions are needed if systems of care are to truly transform.

Personal and Organizational Competition and Conflict

***Stephen Bamber**:* Earlier, I introduced the notion of a recovery economy. This implies competition– for resources, attention, "consumers" and so forth. How do we reconcile these harsh realities of life in a recovery economy and the conflicts these realities can engender with the ideals and aspirations of a recovery advocacy movement?

***William White**:* Movements are about struggle which means they are not for the faint of heart. Movement are turbulent, messy, unpredictable and, at times, very primitive. Movements can magnify the best and worst in us. We went through such messiness—rampant paranoia about which person and organization would lead the movement, underground gossip rather than direct communication, fears of secret deals being made, the scapegoating of early leaders. I think these processes are endemic to all social movements, but they can get magnified in a community of recovering people or in other historically disempowered groups. It's a form of historical trauma that gets acted out in our intragroup relations. That's why nearly all of the recovery mutual aid organizations before AA self-destructed. It wasn't from the lack of a personal recovery program; it was their failure to find principles that could rein in these destructive group processes.

In our case in the U.S., we had many organizations eyeing each other suspiciously, the Johnson Institute's Alliance Project, the National Council and Alcoholism and Drug Dependence, the Legal Action Center, the Center for Substance Abuse Treatment's Recovery Community Support Program with others (particularly the treatment industry) watching closely from the shadows. I think one of the secrets of the success of Faces and Voices of Recovery as a new emerging organization was that it didn't compete; it celebrated all who had contributed, elevated their respective commitments and connected these efforts. Not an easy effort, but nonetheless quite an achievement.

***Stephen Bamber**:* What are the most frequent sources of conflicts that can threaten recovery movements?

***William White**:* I personally think of them as the 5 Ps: Personality (assertion of egos), power and privilege (tensions over status and inclusion), possessions (money and property), press (issues surrounding internal and external recognition) and passion (occasional intragroup disruptions related to relationship dramas of movement members—a particular problem if there is a predatory pattern within such relationships). Regarding the latter, we have to learn how to manage the intensity of interpersonal relationships within the movement. I don't just mean the occasional disruptive intimate relationships that can get sparked amidst the intensity of these movements. I'm including intense friendships and strained project collaborations and relationships between rising and disengaging leaders and organizational members.

In short, if you want to start a fight among a group of people in recovery, give them a position statement they had no input in creating, give them a pile of money, select one of them for a television interview, hire one of them, give a few people fancy titles, or bring into the group mix one or more new members who are young, attractive and unattached. Movements that can't transcend the 5 Ps implode into the dustbin of history. Sometimes there is conflict because there are real issues that need to be sorted

through and for which the best path is not always clear. In the U.S., we had early difficulty sorting out the role of prominent treatment institutions and their representatives. We ended up insisting that people in recovery must lead the movement—that we would not be the marketing and lobbying arm of the private or public treatment industry, and that people who were in recovery and also worked for treatment institutions needed to stay out of their professional roles while involved in movement activities. Now those were clear cut issues we had to address—issues about clarity and integrity of our mission and our goals. Once those boundaries were clear, conflict subsided and there were all kinds of opportunities for positive collaboration.

And I would be remiss if I did acknowledge that conflict sometimes arises from us acting out our own personal sickness and our deeply imbedded and self-destructive patterns of relating to others. People in recovery, like a lot of people, don't always play well together, and some find it easier to get attention from opposition against rather than advocacy for. Every movement has people whose role in life is to stir shit up, but that gets sorted out over time as the compulsive critics lose credibility and are replaced by those who quietly go about the movement's more constructive business. And sometimes there are just big personalities that can launch a movement at the same time they suck the air out of it. Those among our readers familiar with the history of NA will recall that early NA imploded behind the personality of such a leader before NA as it is known today was reborn in 1959. For movements to succeed, such personalities have to be tempered once the movement is jump-started. Those most comfortable speaking from the podium must learn how to listen and the listeners must find their voices. That's how a movement finds balance. Those who are students of recovery history will also recall such balancing process in the relationship between AA's co-founders. It has often been said that if AA had only been founded by Dr. Bob, it would just now be getting out of Akron, Ohio. If it had been founded by Bill W., it would have been commercially franchised throughout the world like McDonalds. Together, these two very different men made the chemistry of their early leadership work. Each had weaknesses and vulnerabilities, but found strength and resilience when they stood together. That discovery became a metaphor for the fellowship as a whole.

***Stephen Bamber**:* What are the most important lessons about the nature of such conflict?

***William White**:* I think it is important to normalize conflict and not attribute it solely to the vagaries of particular people or organizations. Conflict is inevitable and perpetual in recovery advocacy movements for a variety of reasons. The issues are of high import. Effective strategies have not been well charted. Our own character defects and less than ideal relational and problem solving styles inhibit the consensus process. (Consensus requires transcendence of ego and that is not our strong suit as a people.) And we are faced off against people and institutions that bait and provoke such conflicts as a defensive strategy.

Tension and conflict are perpetual because recovery movements, like the recovery process itself, evolve dynamically, reach stuck points and wonder into promising blind alleys—or succeed in ways we don't know how to handle. They are perpetual because the issues keep changing and the players keep changing. I sometimes think of the movement as a long river run—periods of profound bliss interrupted by dangerous rapids. And like river runs, the journey requires careful planning and preparation, constantly checking oneself and one's environment, and the company of companions who can be trusted to have your back. A possible third lesson is that conflict is not in and of itself bad. Movements feed on a kind of creative tension. The important thing is to distinguish between creative tension and destructive conflict.

***Stephen Bamber**:* How do you distinguish these?

***William White**:* Creative tension is when the struggle is about clarifying values, goals, priorities and strategies. It's about needs and possibilities and principles; it's not about ego and ownership of turf. Destructive tension gets personal. That's when we start questioning the recovery pedigrees of individuals and organizations. We start questioning whether people are in recovery, how they got in recovery, how they maintain their recovery, and how long they have been in recovery. We start seeing people as "less than" if they didn't use heroin or enough of it; didn't use needles; didn't spend any or enough time in jail; did not use enough or long enough; didn't experience enough degradation; didn't lose enough; didn't hurt others enough. This was paralleled in the civil rights movement by questioning whether someone was Black enough to lead the movement or whether he or she had paid enough dues.

Of course, this is such total nonsense. You can't judge the quality of recovery by the degree or duration of destructiveness that preceded it. To think in such categories is to extend "dope fiend thinking," as we called it in the early therapeutic communities of the 1960s, into the recovery process. We have to mature to the point of abandoning such categories within the movement and refuse to let others outside the movement, such as the press, professionals or government officials, impose such categories on us.

***Stephen Bamber**:* How is this pecking order related to the stigma and demonization of addiction?

***William White**:* That is the very essence of the issue. You don't see cancer patients organizing themselves into exclusive surgery, chemo, radiation or alternative therapy clubs. We don't see people who have managed depression without medication developing a shared identity and claiming moral superiority over those who have managed their depression with the aid of medication. So why do we see these pecking orders of status in the addiction recovery arena?

The answer seems to me to lie in the stigma attached to addiction and the personal shame that is its legacy. I don't think any of us can escape it. Those of us who have been so judged are, in turn, quick to judge others like ourselves. We who have felt so bad about ourselves can be so quick to claim superiority over others—so quick to fight with each other rather than the real and more powerful enemies of this movement. At the point our discourse deteriorates to that level, the heart of the movement has been lost. The question is whether it has been lost temporarily or permanently.

***Stephen Bamber**:* What is the way out at that point?

***William White**:* We must find a way out personally and collectively. On a personal level, as we mature in recovery, such needs to elevate ourselves over others dissipates. The masks of arrogance and intolerance give way to greater humility and acceptance. When we accept the imperfection in ourselves, it becomes easier to forgive what we see as imperfections in others, some of which later become understood not as imperfections but differences. The differences cease to be a threat, and we can experience true joy for another whose pathway of recovery is different than our own and others whose ideas about what is best for the movement are different from our own. We stop claiming that our way is the TRUE way and instead claim only that it works for us—today. There are very real issues in this movement over which people of good will could and do disagree, but far too much conflict comes from these more primitive processes.

When the conflict gets destructive, some movements die in whole or in part at this point, but others rise from the ashes of such nonsense by confronting and escaping that tendency to draw the circle ever tighter through schisms and purges. You have to create a big tent for a viable recovery advocacy movement. The Connecticut Community of Addiction Recovery did this in

a very unique way. They found a way to rise above all the debates about who could be part of their organization by simply saying, “You are in recovery if you say you are” and embracing families within the concept of recovery.

The first people and organizations who try to organize people in recovery will always have their motives called into question. No one wants to be put under that kind of microscope. It takes a supportive circle of people to help each other get through this stage.

***Stephen Bamber**:* So what do we do when we find ourselves caught up in such processes?

***William White**:* I think we have to recognize what is happening, name it and stop it. We have to honestly examine any part we may be playing in such processes, admit it to ourselves and others, make amends where needed, and get on with the real business of the movement. We have to rise above fighting each other and use our imperfect selves and imperfect organizations to take on the greater challenges that we face. And yes, we will occasionally regress. We have to catch ourselves when that happens, admit it and stop it. That is not to say we won’t have serious disagreements and an occasional need to address the actions of individuals and organizations that are hurting the movement, but these need to be addressed within the movement and not on the front pages of local papers. The recovery communities to whom the movement is accountable will recognize and refuse to vet such individuals and organizations via their refusal to provide personal and financial support. The quiet wisdom of recovery elders can also guide us through such periods.

***Stephen Bamber**:* Are there principles that can guide recovery advocacy organizations and prevent the self-destruction of these movements?

***William White**:* There are many, but I think there are some that are particularly important. Primacy of personal recovery recognizes that the initiation and maintenance of personal recovery is the foundation of our organizations and our larger movement. It is through this principle that we acknowledge that organizational health is contingent upon personal health—that recovery advocacy is not and cannot be a substitute for a personal program of recovery maintenance. The history of recovery advocacy movements is strewn with the bodies of those who thought otherwise. More than any other social movement, we know that we cannot save the world unless we first save (and keep saving) ourselves.

Mission fidelity means that all matters unrelated to the goal of increasing personal, family, community and cultural recovery capital are considered issues beyond the boundary of the organization’s purpose and expertise. This principle helps us keep “our eyes on the prize.” There are a lot of us in the recovery movement involved in multiple causes—it’s an extension of our making amends and giving back to the communities we once wounded. So we have a tendency to want to bring all these other issues into the recovery advocacy movement. We had to learn to say to each other, “This is an important issue, but this is not who we are nor is this the cause for which we came together.”

Authenticity of representation is the assurance that the organization is led by and on behalf of individuals and families in recovery and their vetted allies. It is a pledge of watchfulness on the issue of double-agentry—persons who may present themselves as representatives of the recovery community who, unconsciously or with intent, represent other personal, ideological, institutional or financial interests. This is not to say people who wear such multiple hats cannot contribute to the movement, but it does say that these other potential influences on the movement must be acknowledged and minimized. Nor as we noted earlier does this mean that persons without recovery experience should be denied roles in a recovery advocacy movement. Such movements have always

been aided by persons not in recovery, but the majority of its core leadership must remain with people in recovery.

Transparency and self-inventory are principles assuring that key aspects of organizational character and functioning (e.g., decision-making, financial dealings, organizational alliances and evaluations of organizational effectiveness) are visible to organizational members, local communities of recovery and the larger community. The need for transparency flows from the recognition that the old recovery mantra "We're only as sick as our secrets" applies to organizations as well as individuals. Transparency is an organization's commitment to self-evaluation, its willingness to share the results of such self-scrutiny, and a promise to listen and be guided by its most important constituents. As Bill Wilson once suggested, this requires the capacity to respect one's critics as potential benefactors.

Tolerance, inclusion and partnership are principles that commit the organization to respect for the multiple pathways of long-term personal and family recovery and to the inclusion of people representing these diverse pathways and styles of recovery. These principles also extol the power of the circle—the value of assembling ourselves in a way in which every person has a right to be seen and heard.

Stewardship is a principle that reminds us of the preciousness of the resources we oversee and our responsibility to allocate those resources in the best possible way to support the growth of local recovery capital.

Vigilance is a principle that prevents us from turning our attention from battles we feel have been won. In the US, the recovery advocates of the 1940s, 1950s and 1960s abandoned the intensity of their public education and policy advocacy work to help build new treatment resources which they had helped created. It was with their attention diverted that new efforts to stigmatize, demedicalize and criminalize alcohol and other drug problems rose again. Change once achieved must be aggressively protected.

I think those are among the most important principles, but of course there are the near universal recovery values that also become part of the DNA of the movement—values such as humility, simplicity, respect, tolerance, service, to name a few. But it may not be enough to leave this all to chance. There is value in recovery advocacy organizations setting down and making explicit the values and etiquette that will guide their relationships with one another and with the larger communities within which they are nested.

These implicit or explicit agreements need to become a foundation of the movement in the same way the Traditions have served and continue to serve Twelve Step recovery fellowships. When we as an advocacy movement lose our way as we periodically have and inevitably will again, it is these values and our founding vision to which we must return to re-center ourselves.

***Stephen Bamber**:* I can see how it might be both helpful and harmful to wash the nascent recovery movement's "dirty laundry" in public – by that I mean making public allegations of corruption, malpractice or other nefarious activity. On the one hand it demands instant accountability and action, on the other it can erode mutual trust and create an unhealthy culture of defensiveness, paranoia and 'blame-throwing'. What is the best way to deal with instances of alleged wrong-doing and do you have any advice to offer those who wish to put things right?

***William White**:* First, I think it is important to recognize that recovery movements are no more or less immune to such misdeeds than are political, religious, educational or business organizations. Will there be such personal aberrations? Of course, there will. Could there even be efforts to hijack the movement for financial or ideological gain? Of course, that is a possibility. Those are risks within all social movements. So what stops such misdeeds? There are really two things. First, recovery movements have the ultimate enforcer. When we drift too far from our focus on recovery, we implode personally and we implode organizationally.

That's one of the primary lessons from our history as a people. Second, there is a movement conscience analogous to the group conscience within local recovery fellowships that rises in response to such issues. That can take the form of group consensus or it can come in the voice of an elder or elders of the community whose wisdom is widely respected.

At a personal level, when we see wrongdoing, we can speak out inside our organizations and inside the movement where that is possible, and if we can't find forums to speak, then we vote with our feet and with our pocketbooks. We withdraw our participation and we withdraw our financial support. Now let's make this a little more concrete. What would we do if we discovered evidence that persons seeking help from a local recovery support organization were being sexually exploited by the leader of that organization? Our responsibility would be to help those persons so exploited seek redress through all avenues that are available to them, explore all avenues to stop such exploitation and to assure that such exploitation does not happen in the future. What is important is that we individually and the recovery community are not complicit in such exploitation via our silence and that we have taken all personal and collection action possible to stop such victimization. This is an extension of the recovery process itself to the community as a whole: when wrongs are made, we admit and correct them. We must find the balance between "washing our dirty laundry" in public (actually, it is usually someone else's) and hurting multiple parties through our silence. These decisions are best sorted out in fellowship with others rather than as individuals.

Chronicling Movement History

***Stephen Bamber**:* What suggestions do you have for those in other countries who might serve the role you have played chronicling the US recovery advocacy movement?

***William White**:* I think the nature of such a role could be misunderstood if you only view the end products—the writings and speeches. All of us warm to such visibility and we all want to be seen as clever and wise, but our influence may be determined less by what we say in print or presentation and more by the quality of the questions that we ask and how well we listen to the answers others provide us. The chronicler's most important roles are listening and observing. Everything hinges on that.

As for documenting the history itself, I continue to rely on my mentor's (Dr. Ernie Kurtz) admonitions to: 1) tell the story chronologically, 2) tell the story in context, 3) provide the evidence—ALL of the evidence, 4) separate fact from conjecture and opinion, 5) tell the story from different perspectives, and 6) localize and personalize the story. The famed historian Barbara Tuchman often talked about the challenges of writing history while it was still smoking—when you are still so close up it is hard to see what is significant. The challenge that I and others have chronicling this international recovery advocacy movement is even more difficult–writing about this movement while it is still on fire. We need to chronicle the unfolding of these movements because so much of the early stages of movements are not captured in archival documents and because retrospective memory is so fallible and filtered. Without these chronicles, we have history told only by the survivors whose stories have often been reconstructed to serve personal, organizational or ideological agendas.

Reflections on Personal Role

Stephen Bamber*: How has your own role* as a recovery advocate evolved over the past decade?

William White: I've moved beyond my early roles as Chicken Little—running around telling everyone the sky is falling and that we need to do something about it–and Johnny Appleseed—traveling from community to community spreading seeds of the rising movement. I see myself more in the

background now as a person who performs technical work on behalf of the movement. This includes capturing the movement's history and central ideas and conducting or synthesizing recovery-related research that could add intellectual and scientific credibility to the movement. The former I have always done on a voluntary basis; the latter I have been able to devote more time to in recent years through my professional work on recovery-related research and writing.

Today, I am essentially a servant of these grassroots and professional recovery movements. Individuals and organizations give me my assignments by the questions they raise and then I go off and research, think and write about them and deliver my contributions in the form of papers, monographs and books. I'm too old and physically beat up to continue the travel rigors, so the best way I can now help is at my writing desk.

***Stephen Bamber**:* It strikes me that it is the quality and quantity of individual engagement that ultimately determines the efficacy and success of advocacy movements. What does it take at a personal level to sustain involvement in a recovery advocacy movement?

William White: Movements have insatiable appetites for time and talent and they can suck us dry even as they fill us with deep meaning and purpose. Maintaining balance is critical to sustaining our health during movement participation which is a problem since, as a people, balance has not exactly been our dominant character trait. Our natural inclination is to over-extend so such risks must be consciously self-monitored and achieved through our care and support of one another. Sustaining our health requires the management of impatience and fatigue, a thick skin and sense of humor and careful attention to one's personal and relational health. I've also been recently thinking about what it means to families to have someone deeply invested in these movements. I think we have to find ways to involve our families in movement activities or be extremely careful in balancing family and movement time. Someone I once had in training shared the following admonition which had been passed down through his family of social activists: "One must be careful in carrying light to the community to not leave one's own home in darkness." Those are very profound words.

***Stephen Bamber**:* They are indeed Bill, and a fitting way to draw this second Dialogue to a close. Thank you.



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). Foreword: The emerging UK recovery movement. *Journal of Groups in Addiction and Recovery* (Special Issue: Recovery from Addiction in the United Kingdom). 6(1-2), 5-6. Posted at **www.williamwhitepapers.com**

The Emerging UK Recovery Movement

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

For full text, see

http://www.informaworld.com/smpp/title~db=all~content=g937702489

White, W. & Torres, L. (2010) Recovery-Oriented Methadone Maintenance (Executive Summary). *Counselor*, 11(6), 44-53.

Recovery-Oriented Methadone Maintenance

By William L. White, MA and Lisa-Mojer Torres, JD

Introduction

There are growing calls to shift the acute-care model of addiction treatment to a model of sustained recovery support analogous to the long-term management of other chronic diseases. A new monograph has just been published by two of the Center of Substance Abuse Treatment's Addiction Technology Transfer Centers and the Philadelphia Department of Behavioral Health and Mental Retardation Services. The papers contained in this monograph explore what this shift means to the design and delivery of methadone maintenance (MM) treatment and the status of MM treatment and MM patients in the United States.

The papers have two primary audiences. For addiction treatment professionals and recovery support specialists who have not worked in methadone maintenance treatment, our goals are to:

- provide a primer on the historical evolution and current scientific status of MM treatment,
- explore the controversies surrounding recovery status and methadone maintenance, and
- enlist readers' support for a model of recovery-oriented methadone maintenance (ROMM).

For addiction treatment professionals, recovery support specialists, and patients and their families directly involved with MM treatment, our goals are to:

- document the dissipation of recovery orientation within the evolution of MM treatment,

- engage readers' support to revive and extend such a recovery orientation,
- discuss MM in the context of recent efforts to define and measure addiction recovery,
- describe core clinical practices within MM that would change in the shift toward a model of ROMM, and
- outline strategies to address the professional and social stigma attached to methadone, MM treatment, and MM patients.

The present article provides readers of *Counselor* with an Executive Summary of three of the four papers contained in this new monograph. Those wishing to read the complete monograph may download it for free at either http://attcnetwork.org/regcenters/index_greatlakes.asp or www.williamwhitepapers.com

Executive Summary

Recovery-Oriented Methadone Maintenance Treatment: I. Historical Context

Recovery-Oriented Methadone Maintenance

Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines methadone pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—recovery defined here as remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration.

Distinctiveness of ROMM

ROMM provides an alternative to acute care (heroin detoxification or short-term maintenance) and palliative care (medication maintenance as a strategy of personal pacification and

social control). ROMM is a person-centered model of long-term recovery management.

Opioid Addiction as a Chronic Disease

It was the dream of those who developed methadone maintenance that chronic opioid addiction would one day be addressed with the same treatment philosophies and strategies used to manage other chronic medical disorders. Within this framework, the methadone maintenance patient is viewed on par with patients requiring normalizing doses of insulin, anti-convulsive medication, or hypertensive medication and psychosocial support services. Fulfillment of that vision has been thwarted by the strong anti-medication bias that pervades the history of addiction treatment and recovery in the United States.

Early Treatment History

The treatment of opioid addiction in the United States spans nineteenth-century institutional treatment (inebriate homes, inebriate asylums, and private addiction cure institutes); detoxification by private physicians; exotic and sometimes lethal medical withdrawal procedures; fraudulent proprietary home cures; early twentieth-century morphine maintenance clinics; mid-twentieth-century prison-based treatment ("narcotics farms"); and experiments with aversive conditioning, electroconvulsive treatments, psychosurgery, and psychoanalysis. All were characterized by high rates of resumed opioid addiction following treatment cessation.

The Context for Methadone Treatment

Methadone maintenance was pioneered in the mid-1960s in the wake of a dramatic rise in heroin addiction following the Second World War. Therapeutic pessimism regarding traditional approaches to treatment prompted calls by major policy bodies for new experiments in the maintenance of persons chronically addicted to heroin and other opioids. Methadone maintenance developed amidst competing approaches to this problem: mass incarceration, Narcotics Anonymous, ex-addict-directed therapeutic communities, hospital-based detoxification, alternative pharmacotherapies, experiments with civil commitment, and faith-based outpatient counseling clinics.

The Origin of Methadone Maintenance

Methadone maintenance (MM) was pioneered in 1964 by Dr. Vincent Dole, Dr. Marie Nyswander, and Dr. Mary Jeanne Kreek at Rockefeller Institute for Medical Research (now Rockefeller University) and Rockefeller Hospital. Following early studies on its safety and effectiveness, MM was integrated into multi-modality treatment systems in New York, Illinois, Connecticut, Massachusetts, Pennsylvania, and Washington D.C. and then more widely disseminated in the 1970s within a growing national network of addiction treatment programs in the United States.

Early Theoretical Foundations

MM was based on a metabolic theory of addiction that viewed heroin addiction as a genetically influenced, chronic brain disease requiring sustained medical management—a problem of sickness rather than sinfulness. Metabolic stabilization and maintenance (via individualized, optimal daily oral doses of methadone) were viewed as essential for most patients to achieve successful long-term recovery. MM was defined as "corrective but not curative." It was believed that many, if not most, MM patients would require prolonged if not lifelong pharmacotherapy to sustain their recoveries. In the early-stage theory of MM treatment, biological stabilization was expected to be followed by psychosocial rehabilitation and community reintegration—processes requiring a broad menu of ancillary services and supports.

Early Recovery Orientation

Recovery-oriented practices (those now known to be linked to elevated long-term recovery outcomes) within the early MM model included: 1) rapid access to treatment in early sites (e.g., New York City, Washington D.C.); 2) patient involvement in clinical decision-making; 3) methadone doses (usually 80-120 mgd with no dose ceilings) capable of suppressing withdrawal distress, reducing craving, and inducing a "blockade effect" to other opioids; 4) therapeutic responses to any continued drug use; 5) a chronic care perspective that placed no arbitrary limits on duration of MM participation; 6) emphasis on creating a strong therapeutic alliance

with each patient; 7) use of recovering staff as role models; 8) development of programs for populations with special needs; and 9) the broader mobilization of community resources to respond to addiction, including long-term recovery support needs.

Diffusion of MM

Public and political alarm about heroin-related crime and about heroin use by US soldiers in Vietnam spurred federal investment in addiction treatment and the subsequent diffusion of methadone maintenance in the United States. The number of methadone patients in the US grew from fewer than 400 patients in 1968 to more than 80,000 patients in 1976, with much of that expansion occurring in New York City.

Decreased Recovery Orientation

The regulation and mass diffusion of MM in the 1970s and 1980s was accompanied by changes in treatment philosophy and clinical protocols. The most significant of these changes in terms of recovery orientation included a shift in emphasis from personal recovery to reduction of social harm; increased preoccupation with regulatory compliance; widening variation in the quality of MM programs; the reduction of average methadone doses to subtherapeutic levels; arbitrary limits on the length of MM treatment; pressure on patients to taper and end MM treatment; the erosion of ancillary medical, psychiatric, and social services; and a decreased emphasis on therapeutic alliance between MM staff and MM patients.

The definition of *recovery* during this period shifted from a focus on global health and functioning to an almost exclusive preoccupation with abstinence—then defined as including cessation of methadone pharmacotherapy. The public face of MM became defined by the worst MM clinics and the least stabilized MM patients. Professional, political, and public support for MM as a medical treatment for opioid addiction declined through the late 1970s and early 1980s until the value of MM was revived in the late 1980s as a public health strategy to address the spread of HIV/AIDS. In spite of these challenges, many MM treatment staff continued to promote a vision of recovery, and many MM patients achieved but were forced

to hide their achievement of that vision to avoid the social and professional stigma attached to MM.

.

Methadone Critics

The inevitable backlash to early media reports of methadone as a miracle cure for heroin addiction spawned numerous critics of methadone maintenance treatment. Critics of medication-assisted treatment, many of whom were competing for cultural and economic ownership of the problem of heroin addiction, alleged that MM: 1) substitutes one drug/addiction for another; 2) conveys a societal attitude of permissiveness towards drug use; 3) fails to address the characterological or social roots of heroin addiction; 4) cognitively, emotionally, and behaviorally impairs MM patients; 5) is a tool of racial oppression and genocide; 6) is financially exploitive; and 7) as a result of these factors, is morally unacceptable.

The Revitalization of MM

Since the early 1990s, there has been a revitalization of MM in the United States. This process has included: 1) the scientific reaffirmation of the effectiveness of MM by prominent scientific, professional, and governmental bodies; 2) increased advocacy efforts by MM patients; 3) an expansion of national MM treatment capacity—most notably within the private sector; 4) national efforts to professionalize and elevate the quality of newly rechristened and accredited Opioid Treatment Programs (OTPs); and 5) an expansion of pharmacotherapy choices in the treatment of opioid addiction, e.g., buprenorphine/Suboxone/Subutex. These developments occurred amidst renewed efforts to publicly and professionally portray opioid addiction as a brain disease that can be medically managed with the aid of methadone and other pharmacotherapies. In spite of such advancements, resistance and hostility toward methadone continue from many quarters.

Recovery-Oriented Methadone Maintenance

Two trends are reshaping the future of MM in the United States: 1) a clearer articulation of addiction as a chronic disorder that is best treated through methods used to manage other chronic disorders, and 2) the emergence of recovery as an organizing

paradigm for the addictions field. If sustained, these trends will profoundly change the nature of all addiction treatment, including MM treatment.

The Future of MM

The future of MM in the United States rests on the collective ability of OTPs to forge a more person-centered, recovery-focused medical treatment for opioid addiction and to confront methadone-related social stigma through assertive campaigns of public education and political/professional influence. It also rests on the mobilization of a grassroots advocacy movement of MM patients and their families. An important next step in the developmental history of MM is to define *recovery* within the context of methadone maintenance and within the broader pharmacotherapeutic treatment of substance use disorders.

Recovery-Oriented Methadone Maintenance Treatment: II. Recovery and Methadone

Defining Recovery within the Context of MM

Controversy and stigma continue to surround the use of methadone maintenance as a medical treatment of opioid addiction, in spite of more than four decades' worth of scientific evidence of its effectiveness. Methadone patients continue to be socially marginalized, and their recovery status continues to be debated—even within the professional field of addiction treatment and within communities of recovery. The question of the recovery status of methadone patients cannot be answered without a clear understanding of what constitutes *recovery* from opioid addiction. The definition of recovery applied to the patient in medication-assisted recovery from opioid addiction should be the same as that applied to recovery from any other substance use disorder.

Recovery as More than Intent

Recovery from opioid addiction is more than exhibiting motivation to stop or decelerate drug use. Defining recovery in terms of "he/she is trying" sets a low bar for expectations related to the

methadone maintenance patient's health, functioning, and quality of life. Defining recovery only as a motivational state also contributes to the professional and social stigma attached to methadone, MM treatment, and the MM patient and inhibits MM patients' positive reintegration into the community.

Recovery as More than Remission

Recovery from opioid addiction is also more than remission, with remission defined as the sustained cessation or deceleration of opioid and other drug use/problems to a subclinical level—no longer meeting diagnostic criteria for opioid dependence or another substance use disorder. Remission is about the subtraction of pathology; recovery is ultimately about the achievement of global (physical, emotional, relational, spiritual) health, social functioning, and quality of life in the community.

Core Elements of Recovery

Recent attempts to define addiction recovery (e.g., Betty Ford Institute Consensus Conference, CSAT Recovery Summit, United Kingdom Drug Policy Commission) have focused on three essential elements: a) the resolution of drug-related problems (most often measured in terms of sobriety/abstinence or diagnostic remission), b) improvement in global health, and c) citizenship (positive community re-integration).

Methadone and Recovery

There is growing professional consensus that the stabilized methadone maintenance patient who does not use alcohol or illicit drugs, and who takes methadone and other prescribed drugs only as indicated by competent medical practitioners, meets the first criterion for recovery. MM patients stabilized on medically supervised, individualized, optimum doses do not experience euphoria, sedation, or other functional impairments from the use of methadone as a medication. For the stabilized MM patient, methadone is NOT a substitute for heroin: the motivations for, effects of, and cultural symbolism of using methadone as a medication are vastly different from those associated with heroin use.

Distinguishing Physical Dependence and Addiction

Physical dependence and addiction are not the same: the stabilized methadone maintenance patient—here defined as the patient who does not use alcohol or illicit drugs and takes methadone and other prescribed drugs only as indicated by competent medical practitioners—does not, like many pain patients maintained on opioid medications, meet key definitional criteria for addiction (e.g., obsession with using, loss of volitional control over use, self-accelerating patterns of use, compulsive use in spite of escalating consequences).

Recovery Status of the MM Patient

Denying "abstinence" or "drug free" status to stabilized MM patients (who do not use alcohol or illicit drugs and who take methadone and other prescribed drugs only as indicated by competent medical practitioners) based solely on their status as methadone patients inhibits rather than supports their long-term recoveries.

Varieties of Medication-Assisted Recovery

For stabilized MM patients, continued methadone maintenance or completed tapering and sustained recovery without medication support represent varieties/styles of recovery experience and matters of personal choice, not the boundary and point of passage from the status of addiction to the status of recovery.

MM Patient and Communities of Recovery

The stabilized MM patient is caught in an ambiguous world—separated from cultures of active drug use, denied full membership in cultures of recovery, and socially stigmatized in the larger community. It is time for recovering MM patients to be welcomed into full membership in the culture of recovery and afforded opportunities to pursue full citizenship in their local communities.

Family Recovery in the MM Context

Rarely has the concept of recovery been applied to the families of MM patients. Opioid addiction severely wounds family and kinship relationships—wounds that feed the intergenerational transmission of drug-related problems. Family recovery involves

healing those wounds; reconstructing family roles, rules, and relationships; and enhancing the resistance/resilience/health of all family members. The ultimate aim of family recovery is breaking the intergenerational transmission of drug-related problems.

Seeking a Vanguard of MM Patients

It is unlikely that the recovery status of the MM patient will be fully embraced by policy makers, the public, addiction professionals, and recovery communities until a vanguard of present and former MM patients and their families stand together to offer living proof of the role methadone can play in long-term recovery from opioid addiction. The faces and voices of healthy, fully functioning MM patients will be the most powerful antidotes to the stigma attached to opioid addiction and methadone maintenance treatment.

Multiple Pathways of Recovery

There are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. The MM patient who is stabilized on his/her optimal dose of methadone, abstains from the use of alcohol and other intoxicating drugs, and shows evidence of improving global health and social functioning is in recovery or recovering. Long-term recoveries from opioid addiction with or without the use of methadone (or naltrexone or buprenorphine/Suboxone/Subutex) represent personal styles of recovery and should not be framed in categories of superiority or inferiority, right or wrong, or recovery inclusion or recovery exclusion. Rather than a source of disqualification from recovery status, methadone, provided as a medication under competent medical supervision at proper dosages with appropriate ancillary psychosocial support services, aids long-term recovery from opioid addiction and should be so recognized.

Recovery Definition and the Design of Opioid Treatment Programs

Achieving this vision of recovery as remission, global health, and citizenship for the mass of MM patients will require expanding and elevating the range and quality of clinical and peer-based recovery support services available to MM patients and their families.

It will also require creating the physical, psychological, and cultural space in local communities within which medication-assisted recovery can flourish.

Recovery-Oriented Methadone Maintenance: III. A Vision Statement

The Management of Chronic Disease

Addiction to heroin or other short-acting exogenous opioids shares many of the characteristics of other chronic illnesses. Principles and practices that characterize the effective management of other chronic primary diseases can be adapted to effectively manage and improve long-term recovery outcomes in the treatment of chronic opioid addiction.

Methadone Maintenance and Recovery Management

Recapturing and extending methadone maintenance as a person-centered, recovery-focused treatment of opioid addiction—referred to here as recovery-oriented methadone maintenance (ROMM)—will require a realignment of addiction- and recovery-related concepts, a realignment of core clinical and recovery support practices, and a realignment of the context in which treatment occurs (e.g., policies, regulatory guidelines, funding mechanisms, community recovery support resources). Eight arenas of service practice will be profoundly transformed in the move toward ROMM: 1) attraction, access, and early engagement; 2) assessment and service planning; 3) service team composition; 4) service relationships; 5) service quality and duration; 6) locus of service delivery; 7) assertive linkage to recovery community resources; and 8) long-term recovery check-ups, stage-appropriate recovery support, and when needed, early re-intervention.

Attraction, Access, and Early Engagement/Retention

Methadone maintenance treatment voluntarily attracts more people addicted to heroin and other short-acting opioids than any other addiction treatment modality, but most people in need of treatment for opioid addiction are not currently in treatment, will seek treatment only at late stages of their addictions, will drop out of

treatment before optimum therapeutic effects are achieved, and will experience prolonged addiction/treatment careers before recovery stability is achieved. A key strategy of ROMM is to attract, engage, and retain patients at the earliest stages of problem development, toward the twin goals of shortening addiction careers and extending recovery careers.

Promising practices in enhancing treatment attraction include educational campaigns to reach injection drug users, designed to dispel myths and misconceptions about MM treatment, and assertive community outreach teams that provide visible role models of medication-assisted recovery, engage active users in a "recovery priming" process, mobilize family and kinship support, and resolve obstacles to treatment participation. Access to MM could be increased via expanded public and private funding of MM treatment, distribution of coupons for free treatment, reduction of regulatory obstacles that inhibit rapid access, expedited admission (e.g., interim maintenance—methadone without counseling), and moving stabilized patients to medical maintenance (methadone provided by trained primary care physicians). Promising practices related to engagement and retention in MM include individualized and higher methadone doses (above 60 mgd), increased patient choices, telephone and email prompts following missed appointments, patient education related to the safety and benefits of MM, provision of sustained peer-based recovery coaching, and provision of mental health services for co-occurring mental illness.

Assessment and Service Planning

Practices aimed at increasing the recovery orientation of the assessment and service planning process within MM treatment include shifting from categorical to global assessment instruments and interview protocols; defining the family (as defined by the patient) rather than the individual as the unit of service; using a strengths-based assessment process to identify personal, family, and community/cultural assets that can be mobilized to support recovery initiation and maintenance; viewing assessment as a continual rather than a single-point-in-time intake process (based on the understanding that service needs change across the developmental stages of

recovery); and transitioning from professionally directed treatment plans to patient-directed recovery plans.

Composition of the Service Team

Treatment of chronic diseases, in contrast with the treatment of acute disease or trauma, involves a broader multidisciplinary team and a greater emphasis on peer-support for long-term recovery management. Implementing models of ROMM will involve key staffing changes within OTP programs, including a greater role of addiction medicine specialists in patient/family/community education, increased involvement of primary care physicians, co-location of OTPs and primary health care clinics, greater inclusion of family/child therapists, increased use of current and former patients in medication-assisted recovery as staff and volunteers, and the use of indigenous healers drawn from diverse cultural communities, e.g., leaders of recovery-focused religious and cultural revitalization movements.

The Service Relationship

Service relationships within chronic disease management are distinctive in their duration (measured in years or decades), the degree of intimacy that develops between the service providers and the patient and family, and the broader focus of the relationship—the global health and functioning of the patient and family rather than treatment of a particular health defect. Positive indicators of recovery-oriented service relationships include increased levels of recovery representation at OTP governance, leadership, and service delivery levels; respect for patient opinions and preferences via a choice philosophy; changes in administrative discharge policies; reduced incidence of administrative discharges and other premature disengagements from service; elevating patients' hopes and possibilities; transitioning patients from professionally directed treatment plans to patient-directed recovery plans; and an emphasis on sustained continuity of contact and support across the stages of long-term recovery.

Service Quality/Duration

ROMM involves ensuring six critical areas of service practice: 1) dosing policies that ensure safe induction (optimum, individualized,

and effective dose stabilization); 2) addiction counseling that is focused on building and sustaining a recovery process/partnership rather than the mechanics of dosing or service contact documentation; 3) expanding ancillary resources to address co-occurring medical, psychiatric, and other substance-related problems; vocational/employment/education needs; need for peer-based recovery support; and the needs of patients' families/children; 4) ensuring an adequate period of dose stabilization and psychosocial rehabilitation before any efforts to taper from MM (at least 1-2 years to achieve the best long-term recovery outcomes) and offering increased supports during and following the cessation of methadone maintenance; 5) increasing the percentage of MM patients who successfully complete treatment; and 6) building a strong culture of recovery within the MM service milieu.

The Locus of Service Delivery

ROMM anticipates a greater focus on delivery of recovery support services outside the clinic and the greater integration of medication and other recovery support services within non-stigmatized community environments. Promising practices in this area include shifting from siloed OTPs toward the integration of MM within comprehensive addiction treatment and recovery support centers, the expansion of office-based treatment and medical maintenance, and greater use of neighborhood- and home-based recovery support services. The focus of ROMM is on firmly nesting recovery within the natural environment of each patient or in helping develop an alternative environment in which long-term recovery can be nurtured.

Assertive Linkage to Recovery Community Resources

Peer-based recovery support resources are growing rapidly in the United States via the expanding network of addiction recovery mutual-aid groups, the philosophical diversification of these groups, the emergence of a new addiction recovery advocacy movement, new recovery community institutions, and the emergence of new peer-based service roles (e.g., the recovery coach).

Promising practices for ROMM in this area include active liaison between OTPs and the service committees of local recovery

mutual-aid societies, encouraging/supporting the development of groups specifically for persons in medication-assisted recovery, assertive linkage of patients to the resources of local communities of recovery (including medication-friendly recovery support meetings), using volunteer or paid peer recovery coaches to facilitate patient connections to recovery community resources, coaching patients on ways of addressing medication issues at recovery support meetings, hosting onsite peer recovery support meetings at or near OTPs, sponsoring educational events on medication-assisted recovery for recovery community members, inclusion of indigenous healers and healing practices within OTPs, using patient/alumni councils to visibly celebrate patient recovery milestones, and visibly participating (OTP staff and MM patients/families) in local recovery celebration events.

Long-term Recovery Check-Ups; Stage-Appropriate Recovery Education and Support; and, When Needed, Early Re-Intervention

Most people addicted to opioids experience prolonged addiction careers marked by cycles of treatment, periods of abstinence, resumption of opioid addiction, and treatment re-entry. Assertive approaches to in-treatment and post-treatment monitoring significantly enhance long-term recovery outcomes. We envision a future in which a system of recovery check-ups, peer-based recovery support, stage-appropriate recovery education, assertive linkage to communities of recovery, and early re-intervention will reduce post-treatment mortality and enhance the long-term recovery outcomes of MM patients.

Summary

Put simply, ROMM seeks to:

- attract people at an earlier stage of problem development via programs of assertive community education, screening, and outreach;
- ensure rapid service access for individuals and families seeking help;

- resolve obstacles to initial and continued treatment participation;
- achieve safe, individualized, optimum dose stabilization;
- engage and retain individuals and families in a sustained recovery-focused service and support process;
- assess patient/family needs using assessment protocols that are global, family-centered, strengths-based, and continual;
- transition each patient from a professionally directed treatment plan to a patient-directed recovery plan;
- expand the service team to include primary care physicians, psychologists, social workers, peer recovery support specialists, and indigenous healers;
- shift the service relationship from a professional/expert model to a long-term recovery partnership/consultation model marked by mutual respect, hope, and emotional authenticity;
- ensure minimum (at least one year) and optimum (individualized) duration of treatment via focused retention strategies and assertive responses to early signs of disengagement;
- shift the treatment focus from an episode of care to the management of long-term addiction/treatment/recovery careers;
- expand the service menu to include ancillary medical/psychiatric/social services and non-clinical, peer-based recovery support services;
- extend the locus of service delivery beyond the OTP to non-stigmatized service sites and neighborhood-based, church-based, work-based, home-based, and technology-based (phone/Internet) recovery support services;
- assertively link patients/families to recovery community support resources;
- engage the community through anti-stigma campaigns and recovery community development activities;
- provide post-treatment monitoring and support and stage-appropriate education, support, and (if and when needed), early re-intervention for all patients regardless of discharge status; and

- evaluate MM treatment using proximal and distal indicators of long-term personal and family recovery.

Care will need to be taken to avoid potential unintended consequences of this heightened recovery orientation, e.g., the abandonment of patients who do not yet share this vision of a recovery-transformed life.

It is the authors' hope that readers of *Counselor* will review the new monograph and freshly evaluate the potential role of methadone and other medications in long-term addiction recovery.

Acknowledgments: This Executive Summary is abstracted from a monograph jointly published by the Great Lakes Addiction Technology Transfer Center, the Philadelphia Department of Behavioral Health and Mental Retardation Services, and the Northeast Addiction Technology Transfer Center, in part under a cooperative agreement with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT).

About the Authors: William L. White (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. Lisa Torres (Lisa.Mojer-Torres@dhs.state.nj.us) is a civil rights attorney (admitted to the bars in NY and NJ) providing legal consultation and currently working as the first Consumer & Recovery Advocate for the Division of Addiction Services, Department of Human Services, State of New Jersey. William White and Lisa Torres have served as volunteers for Faces and Voices of Recovery since its inception in 2001.



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.L. & Evans, A.C. (2012) Preserving our historical distinctiveness within service integration initiatives. *Visions: Newsletter of the National Association of Addiction Treatment Providers*, 18(5), 8. Posted at **www.williamwhitepapers.com**

Preserving our Historical Distinctiveness within Service Integration Initiatives

William L. White, MA and Arthur C. Evans, Jr., PhD

The ONDCP National Drug Control Strategy, SAMHSA's latest policy directives and numerous health care reform initiatives all call for greater integration of addiction treatment and the broader arenas of primary and behavioral health care (McLellan, 2011; Rosenberg, 2012). What is open to discussion is not whether service integration will occur, but how that integration can best proceed. We are witnessing the opening salvos in the mainstreaming of addiction treatment in the United States.

In our speeches and publications, the authors have advocated and led experiments in bi-directional service integration. In Philadelphia, we are currently examining the degree to which various integration projects achieve earlier intervention into a broader spectrum of alcohol and other drug problems; deliver addiction treatment within non-stigmatized service sites; provide more comprehensive, holistic and family-centered care; expand venues for post-treatment recovery check-ups and support; enhance long-term recovery outcomes (particularly for persons with multiple co-occurring disorders); and improve stewardship of shrinking economic resources (Evans, 2007; Achara-Abrahams, Evans & King, 2011).

As we proceed as a field, the question is not, "Could persons seeking addiction treatment benefit from increased integration of medical and psychiatric services into their care?" Nor is it, "Would primary and psychiatric health care benefit from great infusion of addiction treatment and related recovery support services?" Those answers, based on existing experiential and scientific knowledge, are a resounding, "Yes!" The question is instead, "What core understandings and core service technologies drawn from addiction treatment must be promoted and protected as addiction treatment achieves greater integration with the larger arenas of behavioral and primary health care?"

The addiction treatment field and NAATP's own membership span diverse settings, philosophies and service menus, but most share a set of core ideas that have informed and distinguished addiction treatment from other service arenas. These include the following:

1) Severe and persistent alcohol and other drug problems constitute a primary, self-perpetuating disorder and not superficial symptoms of other personal, family or environmental stressors.

2) The multiple life problems flowing from addiction can be best resolved within a personalized program of recovery initiation and long-term recovery management.
3) Individuals with high problem severity/complexity (biological vulnerability, high severity, co-morbidity, etc.) and low "recovery capital" (internal/external recovery support assets) are best able to achieve and sustain stable recovery through a process of sustained professional and peer assistance.
4) That assistance is best provided by those who possess special knowledge of the multiple pathways and styles of addiction recovery and special expertise in facilitating the physical, psychological, cultural and often spiritual journey from addiction to recovery.
5) Well-intentioned but uninformed attempts to treat substance use disorders can result, and have resulted, in significant harm to individuals and their families.
6) Addiction recovery is a reality in the lives of millions of individuals and families—a foundational belief and source of hope within addiction treatment milieus.
7) Critical sources of hope within addiction treatment have included the representation of recovering people in the addiction treatment field's paid and volunteer workforce and close linkages between treatment settings and indigenous communities of recovery.
8) Brief biopsychosocial stabilization should not be mistaken for sustainable recovery from addiction; recovery is not durable until it is firmly nested in the community—within the physical and cultural environment of each patient/family (White, 2008).
9) The fruits of addiction treatment are contingent upon access, affordability, competency, service breadth, service duration, and continuity of post-treatment monitoring, support and, when needed, early re-intervention.
10) There is a strong scientific and experiential basis for effective addictions treatment, which should be brought to bear in service delivery regardless of the setting.

The field as a whole needs broad discussions of the sources of such distinctiveness. Our ability or inability to collectively answer this question will shape our perceived legitimacy or illegitimacy as a cultural institution. We would be well served within such discussions to address three related questions: 1) What do we as a field want to achieve through service integration initiatives? 2) What potential harm must we as a field avoid within service integration initiatives? 3) What new ideas and service technologies could be drawn from other fields to elevate long-term recovery outcomes? NAATP could provide a great service to the field by leading these conversations toward consensus and helping us formulate guidelines to help us move through these uncharted waters.

Addiction treatment could disappear within the rubric of service integration leaving in its wake the illusion that addiction treatment is still available to our citizenry. As a field, we cannot let that happen. Bidirectional service integration holds great promise for higher quality and more holistic addiction treatment as well as reaching a far greater portion of affected individuals and families. As a field, we must advocate for processes of service integration that achieve precisely those outcomes.

About the Authors: William White is a Senior Research Consultant at Chestnut Health Systems. Arthur Evans, Jr. is the Commisioner of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

References

Evans, A.C. (2007). The recovery-focused transformation of an urban behavioral health care system: An Interview with Arthur Evans, PhD. Accessed January 17, 2011 at

http://www.nattc.org/learn/topics/rosc/docs/arthurcevensinterview.pdf

Achara-Abrahams, I., Evans, A.C. & King, J.K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In Kelly, J. & White, W. (Eds.) *Addiction recovery management: Theory, science and practice*. New York: Springer Science, pp. 187-208.

McLellan, T. (2011). Addiction and segregation. Accessed September 18, 2012 at http://www.drugfree.org/join-together/addiction/dr-tom-mclellan-addiction-and-segregation

Rosenberg, L. (2012). Primary and behavioral healthcare integration: Threat or Opportunity for addiction treatment organizations? *The Journal of Behavioral Health Services & Research*, 39(2), 101-102.

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.



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. (2012). Addiction treatment and cancer treatment: Personal reflections of a long-tenured addiction professional. Posted at **www.williamwhitepapers.com**

Addiction Treatment and Cancer Treatment: Personal Reflections of a Long-tenured Addiction Professional

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

More than a decade ago, Thomas McLellan and colleagues (2000) published a seminal article in the *Journal of the American Medical Association* comparing addiction to such chronic primary health disorders as cancer, diabetes, and hypertension. In their analysis of these conditions, they noted a similar mix of risk factors, recurrence patterns, and problems of patient adherence to recommended treatments and related lifestyle changes. The article defined addiction as a chronic health problem whose effective management should parallel proven approaches to other chronic medical disorders. The article, because of the prominence of the authors and the journal in which it was published, marked something of a "tipping point" in calls to extend addiction treatment from models of ever-briefer acute biopsychosocial stabilization to models that offered the option of sustained recovery management for those with the most severe, complex, and enduring substance use disorders.

In the years since the McLellan et al. publication, considerable progress has been made in conceptualizing this shift and defining how clinical practices would change within various approaches to recovery management. I have been deeply involved in this movement, particularly in marshaling the scientific evidence to guide this redesign process (White, 2005, 2008a; White, Boyle, & Loveland, 2002), but in recent years, personal encounters with cancer have afforded me an unexpected source of new insights into the question, "How would we treat addiction if we <u>really</u> believed it was a chronic disorder?" This article draws from these personal experiences to compare the treatment of cancer and the treatment of addiction.

Personal Context

Like many people in recovery from addiction, I have long feared that cancer was stalking me. Cancer ran in my family history on par with alcohol and other drug problems, with two of my immediate family members and many extended family members experiencing cancer before my own diagnosis. Similarly, I was a very heavy smoker for more than two decades and,

even after adding nicotine to the list of drugs shed in my life, worried that I might not have escaped its long-term consequences. Cancer seemed always close to me, bringing devastation and death to family, friends, professional colleagues, and many of my peers in addiction recovery. In the early 1990s, I was diagnosed with a blood disorder that has been continuously monitored since then due to the risk that it could morph into leukemia. In 2010, a CT scan revealed a tumor on my right kidney that, due to its location and growth pattern, was suspected of being cancer (greater than 90% odds) but turned out to be benign when surgically removed. In 2012, I was diagnosed with prostate cancer and have undergone treatment over the past months. These experiences have afforded a platform of personal experience and research into cancer treatments that I wish to contrast with prevailing addiction treatment practices.

Early Communication of Risk Factors

When the PSA scores in my routine annual physical doubled within one year, I was sent to a urologist, who first retested my blood only to find that the PSA score had risen considerably further in a month's time. But even before I met the urologist, I filled out forms in his office quite different than those I was used to completing for my primary care physician. These forms elicited four areas of information rarely touched on in such depth in routine medical screening: my family history of cancer (which was extensive, including my father's death from prostate cancer), my history of exposure to alcohol and drugs and the duration and intensity of my smoking history (also extensive); my exposure to environmental toxins (higher than normal because of my work as a young man in the construction trades), and co-occurring conditions that could influence future cancer treatment options (in my case, several conditions of potential concern).

Anyone facing a potential cancer diagnosis is preoccupied with two questions: 1) "Do I have it?" and 2) "Why me?" The third question ("Is it going to kill me, and if so, how quickly?") comes a bit later in the process. Before I met the urologist, several things happened as I filled out forms in his waiting room. First, my fear that I was at elevated risk for cancer was confirmed. Second, I knew a combination of family history, personal lifestyle, and environmental circumstances constituted the sources of that risk. Third, I knew that I had co-occurring medical conditions that would be factors in determining any needed treatment choices and my long-term treatment prognosis. Those conclusions were reinforced by the assessment forms, educational materials in the waiting room, and by my own preparatory Internet searches on prostate cancer. In short, I was psychologically prepared to enter this world of cancer treatment even before my cancer diagnosis was confirmed.

That state of readiness made me wonder: Are those sitting in the waiting rooms of addiction treatment programs similarly prepared?

Presentation of the Diagnosis and Stage Information

My diagnosis of cancer unfolded in a series of five communications: 1) The latest elevation in your PSA calls for a biopsy (which was completed), 2) Your biopsy reveals the presence of cancer in 2 of 12 samples, 3) Your "Gleason Scores" for the positive cancer samples are 6 and 7 (of 10—indicating a pattern of more aggressive growth requiring treatment rather than just monitoring), 4) You will need various scans to determine whether the cancer has spread outside the prostate (which were done), and 5) You have prostate cancer that appears to be contained within the prostate (later confirmed in post-surgical pathology tests) and that is at an early to intermediate stage of development that will require treatment as soon as it can be conveniently scheduled. What was striking about this was that each step involved objective data that could be compared to norms of men with and without prostate cancer, and each step was accompanied by a teaching intervention. In short, I knew exactly the data the diagnosis

was based upon and was taught to understand the meaning of each piece of information. Rather than having a diagnosis thrust upon me, I was invited as a full participant into the diagnostic process. This raised for me the question of how frequently or infrequently the presentation of such objective data, companion teaching interventions, and full participation in the diagnostic process occurs in addiction treatment. I suspect that much of what is characterized as "denial" and "resistance" in addiction treatment flows from the omission of the steps I experienced in my cancer treatment.

Education on Treatment Options

At the time my cancer diagnosis was made, the specialist informed me that the next step was to educate myself on the treatment options. There was no attempt to induct me into a particular form of treatment. Instead, my urologist provided a very well-written educational booklet that outlined multiple (almost too many) options for treatment of prostate cancer with risks and benefits of each objectively outlined. At the next appointment, he reviewed these options with me and said that I would have to decide which would be best for me. When pushed by me for his recommendation, he recommended a particular type of surgery, explained why he recommended that treatment choice, but also insisted that I talk to other specialists about alternative treatment options (which his office helped arrange).

I cannot recall a similar process in my four decades of professional involvement in addiction treatment. It would be rare indeed in addiction treatment to ask a person seeking help to interview people offering different levels of care and different modalities before making a decision about the treatment he or she thought would be best.

Open Acknowledgement of Professional Bias / Second and Third Opinions

In discussing treatment options with the urologist, he explained what his role would be if I chose various surgical options and if I chose various radiation therapies, but he was very clear in stating his bias towards surgery in my particular case and insisted because of that bias that I see others who specialized in non-surgical alternatives. When I chose to compare reports and recommendations from the surgical and radiation specialists with the oncologist who had been monitoring my blood disorder for the past seven years, the urologist was delighted that I had this guide who would not be directly involved in delivering any treatment that I chose. That attitude of acceptance of second and third opinions on treatment options and linkage for such objective consultation are quite rare in the world of addiction treatment as I have observed it.

Objective Comparison of Recurrence and Survival Rates

There is a precision and candidness in discussing cancer treatments that I found quite refreshing. Probabilities were given for the outcomes of no treatment and the respective treatment choices available to me in exact percentages, e.g., five-year rates of cancer recurrence and five- and ten-year survival rates. Not only was I made aware of such rates for each treatment I was considering, but I was also given rates matched to my particular circumstances, which, in comparison to the general rates, quickly eliminated some treatment options and made my best choices clearer. This was a type of "treatment matching" I had not encountered in the addictions field. For example, what data is provided to persons seeking treatment for opioid addiction to help guide their decision of multiple treatment options? In my tenure working in addiction treatment, I have never seen such comparative information routinely provided to persons/families seeking assistance. Why

are such rates not available for addiction treatment? Why are the available limited data on long-term outcomes from no treatment and for various treatment interventions not routinely provided to patients and their families?

Candid Communication of Iatrogenic Risks

All of the providers—surgeons, radiologists, general oncologists—involved in my cancer treatment reviewed the potentially harmful effects of each treatment option I was considering. These spanned potential adverse effects during surgery (e.g., stroke, heart failure), risks resulting from hospitalization (e.g., blood clots, infection), and more prolonged post-surgical risks (e.g., incontinence, impotence). What was more remarkable was that they communicated the exact numerical probabilities of each of these risks and implemented specific procedures to reduce these risks, e.g., heparin injections and leg massages to prevent blood clots and stroke, antibiotics to prevent infection, and specific surgical techniques to reduce the risk of long-term incontinence and impotence.

There is a long tradition of iatrogenic effects (harm in the name of help) within the history of addiction treatment (White, 1998; White & Kleber, 2008), but patients entering addiction treatment are not routinely apprised of such risks or of their frequency of occurrence, even though some data related to such risks are available in the scientific literature (Ilgen & Moos, 2005; Moos, 2005).

Access to Experiential Knowledge

The sometimes clinical precision of information about the course of cancer, treatment options, and the outcomes of various cancer treatments was balanced by access to a very different type of knowledge—the experiential knowledge of patients in various stages of recovery who had experienced the exact treatments I was considering. This was made available through face-to-face and Internet-based patient support groups and innumerable websites at which questions could be posed and answered by the broad experience of patients—both locally and from across the world. Imagine what it would mean to individuals and families considering addiction treatment to have access to that kind of experiential knowledge—before, during, and after the treatment process.

Patient Choice, Partnership, and Family Involvement

Cancer is such a terrifying diagnosis that one might well imagine the value of a medical superhero riding in on a white horse to take control and save the day, but cancer treatment is often quite different than that image. I had a specialist who insisted that the choice of treatments was mine, not his, and that his role was to educate me about those choices and to execute as best he could the decisions that I made. In fact, after reviewing all of my choices, I had to practically pry out of him what he thought would be the best choice for me. It was clear that what we were entering into was an extended partnership rather than my being the passive recipient of his knowledge and expertise.

One fears the “if you only have a hammer, everything looks like a nail” phenomenon when facing such a life-threatening crisis—the fear that all surgeons want to cut, all radiologists want to radiate, etc.—but I had the novel experience of a surgeon talking positively about radiology treatment and a radiologist affirming that I was a good surgery candidate. What was most striking was that each specialist I saw treated me as an intelligent person who was capable of evaluating choices and making a good decision. Also striking was their comfort, including my wife in every step of the decision-making process. They listened to both of us and responded fully to each of our questions.

In contrast to the above, people seeking specialized help for alcohol and other drug problems are less likely to be given a spectrum of treatment choices, more likely to be dictated a particular type of

treatment by a self-defined expert (usually the primary type of treatment provided by the organization conducting the assessment), more likely to be presented with a professional "my way or the highway" stance, and less likely to have their family involved in all aspects of their treatment (White, 2008a).

Education on Treatment Procedures

Once a decision had been made on the type of cancer treatment that would be best for me, the urologist provided further information on the procedure, including a DVD illustrating exactly how the procedure would be performed. He again went over risks and side effects and their prevalence both nationally, in his practice, and at the local hospital where my surgery would be conducted. Again, I understood why this procedure was one of the best choices for me, how it was to be done, the sequence of my care, and what I could realistically expect as an outcome. It isn't that in addiction treatment we don't do that kind of patient education; we do. It is that the depth of patient education in the cancer arena far exceeds anything I have seen in the addiction treatment field.

Management of Co-occurring Conditions (Whole Person)

Cancer, like addiction, often co-presents with related and unrelated health conditions that require concurrent or sequential treatment. For me, management of these co-occurring conditions was considered within my treatment choices and actually eliminated some possibilities. I did not have the feeling of being a machine being worked on by a mechanical expert—the surgeon as expert craftsperson with little awareness of me as a whole person. That was exhibited in a number of ways—clear assessment of co-occurring conditions, openness to having other physicians involved in the decision-making process, respect for their opinions, help in sequencing needed medical procedures across multiple practitioners, and respect for my decisions related to that sequencing.

As I went through this experience, I was struck by how rare those precise ingredients were in addiction treatment. For example, I did not want my treatment to interfere with the forthcoming "robing ceremony" related to my daughter's PhD completion. Information was provided on risks related to the timing of treatment initiation, and treatment was scheduled to begin right after this important event in my life. I suspect few addiction treatment programs would have been so accommodating.

Treatment Duration Based on Measurable Clinical Benchmarks

I am sure there were arbitrary insurance-influenced limits on the length of my hospitalization following surgery, but the timing of my discharge was linked to very clear clinical benchmarks. These benchmarks included both factors that were not present (e.g., fever and other signs of infections) and measurable markers of post-surgical recovery (e.g., kidney functioning, reductions in pain, mobility). In other words, my treatment was shaped by my personal response to treatment and not by an artificial length of stay. That made we wonder how that very clinical benchmarking process could be more widely applied to the treatment of addiction. In fact, my surgeon insisted I would be discharged as soon as possible because the risk of infection rose with the length of hospitalization.

Plan for Long-term Monitoring and, if Needed, Early Re-intervention

My diagnosis of cancer was accompanied by two communications consistently reinforced over the course of my treatment:

1) There is a risk of cancer recurrence even under the best of circumstances (e.g., risk of recurrence even with 100% compliance with all treatment protocols and follow-up

recommendations for preventive care).

2) The morbidity and mortality associated with cancer recurrence can be significantly lowered by sustained monitoring (for at least five years) and, if and when needed, early re-intervention.

Part of the partnership involved not just getting through acute treatment but participating in scheduled checkups, identifying at the earliest possible time any return of cancer, and in the face of any recurrence, assertively re-intervening with renewed and potentially different treatment. So I voluntarily entered and committed myself to a partnership that I knew at a minimum would last five years and probably all of my life. That did not mean that I would be undergoing active treatment forever; it did mean that the most important risk predictors (e.g., findings from lab tests) would be monitored on a set and sustained schedule. Like many cancer patients, I also received information that if I achieved five years of sustained remission, the risk of future recurrence would significantly decline after that critical milestone.

At the time I was given this information, I had been researching an interesting question: When is present recovery from addiction predictive of lifetime recovery? What I had found consistently in my review of long-term treatment outcomes studies (see White, 2008b) was that the stability point of addiction recovery (the point at which risk of future relapse in one's life dropped below 15%) was on average 4-5 years of sustained remission—precisely the range I was being given for stability of my long-term recovery from cancer. In the world of cancer treatment, patients are assertively monitored for the five years following treatment, but patients in addiction treatment receive no such sustained system of monitoring, support, and early re-intervention. Expensive, cyclical episodes of acute addiction treatment are available but nothing resembling the assertive follow-up following cancer treatment is standard practice in addiction treatment.

Absence of Contempt or Condescension

One could easily build a case that prostate cancer was for me simply a bad roll of the genetic dice, but when one looks at the larger risks of cancer in my lifetime, there are clear areas of potential culpability. I was aware of my family history and yet chose to embark on a career of heavy nicotine, alcohol, and other drug use. My overall health management (e.g., diet, exercise, stress, etc.) was not one that could be expected to lower my cancer risks. And yet, my cancer treatment unfolded within service relationships completely free from judgment, contempt, or condescension. Nor did I face any threats of punishment for the sin of noncompliance with treatment protocol. In short, I was treated like a patient who could fully and responsibly participate in my own treatment. I was not treated like a morally culpable criminal or recalcitrant child who needed to be aggressively controlled by my moral superiors—attitudes that too often still permeate the milieus of addiction treatment.

Implications

If we <u>really</u> believed addiction was a chronic disorder on par with cancer (and other chronic primary health disorders), we would provide every person seeking assistance:

- Clear and consistent communications regarding the intrapersonal, interpersonal, and environmental factors that contribute to the development of a substance use disorder.
- An assessment process that is comprehensive, transparent, and continual.
- Objective data upon which a substance use disorder (SUD) diagnosis is based (with normative data for comparison to the general population and to other patients being treated for SUDs).
- Objective information on the severity (stage) of the SUD.

- Objective information on treatment options matched to the type and severity of the SUD.
- A declaration of potential professional/institutional biases related to diagnosis and treatment recommendations.
- A menu of treatment options before making a final decision on the course of treatment.
- Access to the experiential knowledge of former patients who have experienced a variety of SUD treatments and who represent diverse pathways and styles of long-term recovery management.
- Personalized refinements in treatment-based assessment data and individual responses to initial treatment.
- At least five years of monitoring and support following completion of primary treatment.
- Assertive re-intervention and recovery re-stabilization in response to any signs of clinical deterioration.
- A long-term, person- and family-centered recovery support relationship based on mutual respect that is free of contempt or condescension.

It really is that simple. If we believe that addiction in its most severe forms is a chronic disorder, then let's treat it like we really believed it.

References

Ilgen, M., & Moos, R. (2005). Deterioration following alcohol-use disorder treatment in Project MATCH. *Journal of Studies on Alcohol*, *66*, 517-525.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695. doi:10.1001/jama.284.13.1689

Moos, R. H. (2005). Iatrogenic effects of psychosocial interventions for substance use disorders: Prevalence, predictors, prevention. *Addiction*, *100*, 1240-1248. doi:10.1111/j.1360-0443.2005.01073.x

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. L. (2005). Recovery management: What if we really believed that addiction was a chronic disorder*? GLATTC Bulletin*, September, 1-8. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. L. (2008a). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

White, W. L. (2008b). *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. L., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-130. doi:10.1300/J020v20n03_06

White, W. L., & Kleber, H. D. (2008). Preventing harm in the name of help: A guide for addiction professionals, *Counselor*, *9*(6), 10-17.

White, W.L. (2012). Historical perspectives on recovery support. Briefing paper presented at the UCLA / Betty Ford Institute Annual Recovery Conference, Rancho Mirage, CA, February 21-23, 2012.

Briefing Paper
Betty Ford Institute/UCLA Annual Conference on Recovery

Historical Perspectives on Addiction Recovery Support

William White

Support for the personal resolution of severe and persistent alcohol and other drug (AOD) problems in the United States has for most of the past two centuries been provided through three primary mechanisms: family, kinship, and informal social networks; peer-based recovery mutual aid societies; and professionally directed addiction treatment. Today, new recovery support systems are emerging that are without historical precedent and that will exert a profound influence on the future of addiction treatment and recovery in the United States and throughout the world. Even the most cursory discussion of these changes requires a new recovery-focused lexicon.

Historical Context: In a recent paper prepared for a special issue of the *Journal of Groups in Addiction and Recovery*, White, Kelly, and Roth[1] 1) reviewed the historical evolution of addiction treatment and the growth and diversification of recovery mutual aid societies in the United States,[2] 2) documented the emergence of a *new recovery advocacy movement*[3] and *new recovery support institutions* (e.g., national and local recovery community organizations, recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes, etc.),[4] 3)

[1] White, W., Kelly, J., & Roth, J. (in press). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*.

[2] Also see Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

[3] Also see White, W. L. (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; White, W. L. (2007). The new recovery advocacy movement in America. *Addiction, 102*, 696-703. doi:10.1111/j.1360-0443.2007.01808.x

[4] Also see Valentine, P. A., White, W. L., & Taylor, P. (2007). *The recovery community organization: Toward a working definition and description*. Posted at http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf; Molloy, J. P., & White, W. L. (2009). Oxford Houses: Support for recovery without relapse. *Counselor*, *11*(2), 28-33; White, W. L., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58; White, W. L., & Whiters, D. (2005). Faith-based recovery: Its historical roots. *Counselor*, *6*(5), 58-62.

described how these new institutions are being nested within an increasingly well-defined *culture of recovery* (with its own history, values, language, literature, symbols, rituals, art, music, etc.) influenced by but now transcendings pre-existing and insular treatment and recovery mutual aid cultures, and 4) discussed the implications of these changes to the addiction treatment enterprise. This brief paper extends the discussion within that paper.

Recovery as an Organizing Paradigm: In tandem with, or possibly as a result of, the above outlined changes, *recovery* is emerging as a new organizing paradigm within the alcohol and drug problems arena.[5] This is evidenced by: 1) early criticisms that addiction treatment had become detached from the larger and more enduring process of addiction recovery;[6] 2) the reconceptualization of addiction as a chronic disorder;[7] 3) growing interest in the *varieties, pathways, styles, stages, and degrees of long-term addiction recovery*—both *personal recovery* and *family recovery*;[8] 4) explorations of the role of medication in recovery initiation and/or maintenance, e.g., *medication-assisted recovery*, *recovery-oriented methadone maintenance*;[9] 5) calls to extend addiction treatment from a model of acute biopsychosocial stabilization to a broader model of sustained *recovery management* (RM) and to wrap RM within larger *recovery-oriented systems of care* (ROSC);[10] 6) multiple efforts by policy, clinical, research, and recovery advocacy leaders to achieve consensus on a *recovery definition* and *measurable benchmarks of recovery*;[11] 7) federal, state, and local *recovery-focused systems*

---

[5] El-Guebaly, N. (in press). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine*. doi:10.1097/ADM.0b013e31823ae540; White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 3-15. doi:10.1300/J020v23n01_02

[6] Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction And Recovery, 6*(2), 11-23; Morgan, O. J. (1995). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly, 12*(1), 59-71. doi:10.1300/J020v12n01_05

[7] Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice, 4*(1), 45-55; Flaherty, M. (2006). *Special report: A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery—A shift from an acute care to a sustained care recovery management model*. Pittsburgh: Institute for Research, Education and Training in Addictions; McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

[8] White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.

[9] Institute for Research, Education and Training on Addictions (IRETA). (2010). *Recovery-oriented methadone: Improving practice to enhance recovery* (Report prepared for Southwest Behavioral Health Management, Inc.). Pittsburgh, PA: IRETA; White, W. L., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center; White, W., Parrino, M., & Ginter, W. (2011). *A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions*. Commissioned briefing paper for SAMHSA's A Dialogue on Psychopharmacology in Behavioral Healthcare meeting, October 11-12, 2011. Posted at www.williamwhitepaers.com

[10] Kelly, J., & White, W. L. (2011). *Addiction recovery management: Theory, science and practice*. New York: Springer Science.

[11] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*, 221-228. doi:10.1016/j.jsat.2007.06.001;

transformation initiatives;[12] 8) efforts to define RM and ROSC practices for particular populations and cultural contexts;[13] 9) the rapid expansion of *peer-based recovery support services*,[14] new service roles, e.g., *recovery coaches*,[15] and new systems for recruiting, training, credentialing, and supervising recovery coaches; 10) growing interest in post-treatment monitoring and support, e.g., *recovery checkups* and other *assertive or adaptive approaches to continuing care*;[16] 11) calls for a *recovery research agenda*;[17] and

---

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment, 33*, 243-256. doi:10.1016/j.jsat.2007.04.014; McLellan, A. T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment, 38*, 200-201. doi:10.1016/j.jsat.2009.11.002; SAMHSA (2009). Working definition of recovery. Excerpt from *National Summit on Recovery Conference Report, 2005*. Rockville, MD: Center for Substance Abuse Treatment. Posted at www.williamwhitepaers.com; United Kingdom Drug Policy Commission. (2008). *A consensus definition of recovery*. Retrieved June 24, 2010 from http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf; White, W. L. (2007b). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*, 229-241. doi:10.1016/j.jsat.2007.04.015

[12] White, W. L. (2008). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright)*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[13] Haberle, B., & White, W. (2007). *Gender-specific recovery support services: The evolution of the Women's Community Recovery Center*. Posted at http://www.facesandvoicesofrecovery.org/pdf/White/white_haberle_2007.pdf.; White, W.L., Evans, A.C., Ali, S., Abrahams, I., & King, J. (2009). *The recovery revolution: Will it include children and adolescents?* Philadelphia: Department of Behavioral Health and Mental Retardation Services; White, W. L., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly, 26*(3), 365-395. doi:10.1080/07347320802072198

[14] White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

[15] Loveland, D., & Boyle, M. (2005). *Manual for recovery coaching and personal recovery plan development*. Posted at http://www.bhrm.org/guidelines/addguidelines.htm; White, W. L. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor, 5*(6), 20-22; White, W. (2006). *Sponsor, recovery coach, addiction counselor: The importance of role clarity and role integrity.* Philadelphia, PA: Philadelphia Department of Behavioral Health.

[16] 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. doi:10.1016/S0149-7189(03)00037-5; Dennis M. L., & Scott, C. K. (in press). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence*. doi:10.1016/j.drugalcdep.2011.07.026; Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). 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. doi:10.1111/j.1360-0443.2006.01648.x.; McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction, 100*(11), 1594-1610. doi:10.1111/j.1360-0443.2005.01208.x

[17] Laudet, A., Flaherty, M., & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center. Laudet, AB. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Substance Use & Misuse, 43*, 2001-2020. doi:10.1080/10826080802293459; White, W., & Chaney, R. (in press). Commentary--Resilience and recovery across the generations: A critical research agenda. *Counselor*;

12) *recovery prevalence surveys* and *recovery resource mapping* projects. It remains to be seen whether recovery will be a viable and sustained or ephemeral organizing concept for the AOD problems arena.[18]

The Ecology of Resilience and Recovery: One of the by-products of this evolution in thinking and practice is growing interest in what might be called the *ecology of resilience and recovery*—the multi-directional influences exerted by person, family, neighborhood, workplace, school, church, community, and culture on AOD problem resilience, resistance, and recovery.[19] This interest includes a heightened focus on how these contextual influences interact with personal/family vulnerabilities to perpetuate or break intergenerational cycles of addiction and related problems. Future breakthroughs in addiction treatment and recovery support may well lie in the integration of neurobiological and psychological understandings of addiction and recovery with broader frameworks that focus on environmental (physical, social, and cultural) factors.

Key Propositions: The trends outlined by White, Kelly, and Roth rest on several propositions that are explicitly outlined below.

1. Addiction recovery often involves a journey between two physical and cultural worlds—*passage from a culture of addiction to a culture of recovery*.[20] The weight of personal and historical baggage can delay and impede this journey, particularly where alcohol and other drugs have been used as tools of colonization and oppression.[21]

2. The physical, emotional, and cultural passage from addiction to recovery can be aided by exposure to *wounded healers*[22]—persons who have survived and

---

White, W., & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, *19*(2), 20-25.

[18] White, W. L. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

[19] White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36,* 146-158. doi:10.1016/j.jsat.2008.10.006

[20] White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

[21] See Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.; White, W., & Sanders, M. (2002). Addiction and recovery among African Americans before 1900. *Counselor, 3*(6), 64-66; O'Connor, G. (ND). *Recognizing and healing malignant shame*. Retrieved March 3, 2012 from http://www.zonezero.com/magazine/essays/distant/zreco2.html

[22] Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*, 443-456; Jackson, S. W. (2001). The wounded healer. *Bulletin of the History of Medicine, 75*, 1-36; McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books; Ungar, M., Manuel, S., Mealey, S., Thomas, G., & Campbell, C. (2004). A study of community guides: Lessons for professionals practicing with and in communities. *Social Work, 49*(4), 550-561. doi:10.1093/sw/49.4.550; White, W. L. (2000). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly, 18*(1), 1-23. doi:10.1300/J020v18n01_01; White, W. L. (2000). The history of recovered people as wounded healers: II. The era of

extracted lessons from their own personal/family recovery experience—and by assertive linkage to one or more *communities of shared recovery experience*.

3. *Recovery is contagious*. Like addiction, recovery is often transmitted interpersonally, but, in contrast to addiction, is transmitted by affection rather than infection.[23] Many people catch recovery before they choose it.[24]

4. *Recovery prevalence in a neighborhood, social institution (e.g., school or workplace), community, or culture is influenced by the density of recovery carriers*—persons in recovery who are committed to carrying a message of hope to those individuals and families still experiencing AOD problems.

5. Carrying the recovery message interpersonally is as beneficial to the recovery carrier as to the recipients of such messages[25] through what Frank Riessman christened the helper principle.[26]

6. *Recovery prevalence* (the proportion of people with lifetime AOD problems who have resolved those problems) *and the density of recovery carriers* (the number of people in recovery active in service work within a community at any point in time) *constitute crucial elements of community recovery capital*—resources within a local community that can be identified and mobilized to help individuals and families initiate and sustain addiction recovery.[27]

7. *Long-term recovery outcomes* related to participation in addiction treatment, a recovery mutual aid society, and/or other forms of peer recovery support may hinge as much on the existence, accessibility, scope, and depth of community recovery capital as it does intrapersonal or interpersonal factors within the family.[28]

---

professionalization and specialization. *Alcoholism Treatment Quarterly*. *18*(2), 1-25. doi:10.1300/J020v18n02_01

[23] A distinction first brought to my attention by Kathy Griffin.

[24] White, W. L. (2010). *Recovery is contagious*. Posted at www.facesandvoicesofrecovery.org and www.williamwhitepapers.com

[25] Pagano, M. E., Friend, K. B., Tonigan, J. S., & Stout, R. L. (2004). Helping others in Alcoholics Anonymous and drinking outcomes: Findings from Project MATCH. *Journal of Studies on Alcohol*, *65*, 766-773; Zemore, S. E., Kaskutas, L. E., & Ammon, L. N. (2004). In 12-Step groups, helping helps the helper. *Addiction*, *99*, 1015-1023. doi:10.1111/j.1360-0443.2004.00782.x; Witbrodt, J., Kaskutas, L, Bond, J., & Delucchi, K. (2012). Does sponsorship improve outcomes above Alcoholics Anonymous attendance? A latent class growth curve analysis. *Addiction*, *107*, 301-311. doi:10.1111/j.1360-0443.2011.03570.x

[26] Riessman, F. (1965). The "helper" therapy principle. *Social Work*, April, pp. 27-32.

[27] White, W. L. (2011). *Recovery/remission from substance use disorders: An analysis of reported outcomes in 415 scientific studies, 1868-2011*. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center; White, W. L., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, *9*(5), 22-27.

[28] Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231-238; Moos,

8. *The density of recovery carriers within a local community can be strategically increased* through such activities as hosting regular recovery celebration events, honoring local recovery carriers, training recovery advocates and recovery coaches, and offering storytelling training to all persons in recovery.[29]

9. *Community recovery capital can be strategically increased* by nurturing the development of secular, spiritual, and religious recovery mutual aid options, recovery support groups for special populations/needs, peer recovery support service projects, and by supporting recovery advocacy activities that create a community climate (beliefs, attitudes, policies, recovery visibility) in which recovery can flourish.[30]

10. *The strategic expansion of recovery support institutions and the development of vibrant local recovery cultures could result in several important outcomes:*

    - Increased rates of natural recovery—the number of people, particularly those with lower AOD problem severity and complexity, initiating and sustaining recovery without participation in addiction treatment.
    - Increased retention and recovery rates within addiction treatment and recovery mutual aid organizations, particularly among those individuals who present with high problem severity/complexity/chronicity and low recovery capital.
    - The discovery of particularly potent combinations and sequences of professional and peer supports capable of generating long-term recovery outcomes better than could be achieved through any of these elements used in isolation, e.g., the biopsychosocial equivalent of the AIDS "cocktail" or combined surgery and chemotherapy for cancer.
    - The discovery of particular service/support combinations/sequences that work best with key populations, e.g., women, adolescents, people with co-occurring disorders, people re-entering the community from prison, etc.[31]

11. The emergence of a new recovery advocacy movement, new recovery institutions, and a flourishing national culture of recovery is stirring interest in the concept of *community recovery*—the idea that there are neighborhoods or whole communities wounded by AOD and related problems to the extent that they may

---

R. H., & Moos. B. S. (2007). Protective resources and long-term recovery from alcohol use disorders. *Drug and Alcohol Dependence*, *86*, 46-54. doi:10.1016/j.drugalcdep.2006.04.015

[29] White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36,* 146-158. doi:10.1016/j.jsat.2008.10.006

[30] Ibid.

[31] White, W., Kelly, J., & Roth, J. (in press). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*.

require their own community-level recovery process—what the Native American *Wellbriety* Movement has cast as a *Healing Forest*.[32]

12. Particularly promising are strategies that integrate personal, family, and community intervention strategies over a prolonged period of time via the increased integration of prevention, early intervention, treatment, recovery support, and health and wellness initiatives. This will entail bridging clinical models of intervention with environmentally focused public health models. For addiction treatment providers, this will involve blending traditional (intrapersonal) strategies of clinical intervention with broader recovery-focused community development and cultural revitalization strategies.

Summary

The history of help to resolve severe AOD problems has evolved through six overlapping areas of development:

1) failing to adequately address severe, complex, and often chronic AOD problems in non-specialty service settings (a continuing theme),
2) creating specialty-sector addiction treatment resources to facilitate recovery initiation (biopsychsocial stabilization) within an institutional environment,
3) extending acute treatment services into the community (via community-based outpatient care and early intervention efforts in medicine, business and industry, education, and allied health and human services),
4) achieving recovery maintenance through closed addiction recovery mutual aid societies,
5) extending acute care models of addiction treatment toward models of sustained recovery management (currently under way), and
6) an emerging era of mobilizing recovery communities to create the physical, psychological, social, and cultural space in which personal/family life in long-term recovery can flourish and to help heal larger wounded systems (e.g., families, neighborhoods, communities).

This history reflects discrete areas of focused attention: buttressing the will to recover, codifying the means of maintaining recovery, enhancing the quality of personal/family life in long-term recovery, and creating a healthy community milieu within which AOD problems can be prevented and long-term addiction recovery can be firmly nested. Calls for professional models of sustained recovery management and the creation of recovery-oriented systems of care seek, in their essence, to link and fully integrate these historical developments. That achievement would exert a potentially profound influence on the future of addiction treatment and recovery and the global health of families, communities, and societies.

---

[32] Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.; *The Red Road to Wellbriety*. (2002). Colorado Springs, CO: White Bison, Inc.



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. (2012). A brief history of recovery orientation in addiction counseling. Posted at www.williamwhitepapers.com (Prepared for inclusion in Recovery to Practice Situational Analysis developed by NAADAC, the Association for Addiction Professionals under contract with SAMHSA) Posted at **www.williamwhitepapers.com**

A Brief History of Recovery Orientation in Addiction Counseling

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The profession of addiction counseling is historically rooted in the lived experience of recovery, but the degree of recovery orientation in addiction counseling has ebbed and flowed over the course of the e field's history. Four overlapping eras illustrate the evolution in the field's recovery orientation—recovery orientation here defined as respect for recovery-based experiential knowledge, a focus on the facilitation of long-term personal/family recovery, adherence to recovery-linked and scientifically-grounded service practices, and emphasis on the role of community recovery capital in the initiation and maintenance of personal/family recovery.

Recovery Roots of Addiction Counseling

The birth of a specialized helping role to facilitate the resolution of alcohol and other drug problems can be traced to the first persons recovering from such problems who committed their lives to helping others similarly affected. In the United States, such roles included the leaders of 18th and 19th century Native American abstinence-based religious and cultural revitalization movements and the "reformed" temperance missionaries within the Washingtonian Temperance Society (1840s), recovery-focused fraternal temperance societies (1840s-1870s), the Ribbon Reform Clubs (1870s), and such local recovery mutual aid groups as the Drunkards Club in New York City (Coyhis & White, 2006; White, 2000a).

Collectively, these individuals shared their recovery stories in public and private meetings, penned recovery-focused pamphlets and autobiographies, conducted private consultations with individuals and families experiencing addiction-related problems, helped organize local recovery support groups, and maintained prolonged and prolific correspondence with those seeking recovery (White, 1998). The employment of such charismatic recovering figures within the rising network of mid-19th century inebriate homes, inebriate asylums, and private addiction cure institutes marked one of the first controversies and professional splits in the field of addiction treatment. Inebriate homes were often founded and directed by persons in

recovery, maintained close links to local recovery mutual aid societies, and emphasized the importance of public commitment (signing the abstinence pledge), sober fellowship, service to others and the value of short voluntary stays to prime the recovery process. In contrast, inebriate asylums were physician-directed and emphasized physical methods of prolonged, legally mandated institutional treatment emphasizing medical treatments aimed at cure. Inebriate asylum directors attacked the hiring of "reformed men" on the grounds that:

> *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).

The tensions between the inebriate homes, asylums, and institutes; experiential knowledge versus professional knowledge; and recovery support versus medical cure were lost in the larger collapse of addiction treatment and recovery mutual aid groups in the opening decades of the 20th century.

The Addiction Counselor as Paraprofessional Recovery Specialist

The collapse of 19th century addiction treatment in the U.S. left those with the most severe alcohol and other drug problems abandoned to inebriate penal colonies, the back wards of aging state psychiatric asylums, or the "foul cells" of large public hospitals. Those conditions spawned new recovery support efforts, including clinics that trained people in recovery as "lay therapists." Courtenay Baylor, Francis Bishop, and Richard Peabody were among the earliest and most distinguished of such lay therapists and might well be called the first addiction counselors in the United States. This lay therapy tradition was carried forward by Ray McCarthy and others within the Yale alcoholism clinics of the mid-20th century and the extension of Alcoholics Anonymous sponsors into what were first called "AA counselors." IT was further extended with the hiring of "ex-addicts" in the growing network of therapeutic communities, methadone maintenance programs, and outpatient counseling clinics in the 1960s and early 1970s. This emerging "paraprofessional" counselor role incorporated multiple dimensions—the tradition of recovery storytelling (self-disclosure), mutual recovery support, counseling (new skills incorporated from the fields of psychiatry, psychology, and social work), and community recovery resource development and linkage (White, 1998, 1999). The paraprofessional era was marked by high recovery representation within the addiction treatment workforce, close linkages between treatment and local recovery communities (particularly AA), and an emphasis on experiential versus professional/scientific knowledge. The primary and sometimes exclusive credentials the paraprofessional addiction counselor brought to his or her role were personal recovery and a passion to help others recover (White, 1998, 2009b).

Professionalization of Addiction Counseling

The professionalization of addiction counseling unfolded within the emergence of a specialized, revitalized field of addiction treatment—the growth of local treatment programs; formally designated state and federal agencies responsible for planning, funding, and evaluating treatment programs; the extension of insurance coverage for the treatment of alcoholism and other addictions; the rise of hospital-based and private addiction treatment programs; and the emergence of addiction treatment program licensure and accreditation standards. To achieve public and professional credibility,

this rebirthed field required an expanded and credentialed addiction counseling workforce.

Two milestones significantly shaped the addiction counselor role. First, addiction treatment migrated toward an acute care intervention (modeling itself on the hospital via early accreditation standards) rather than on the models of more extended recovery support that prevailed during the paraprofessional era. Second, the role of addiction counselor was modeled on clinical functions performed by psychiatrists, psychologists, and social workers. Notably, key functions were lost in this transition, e.g., assertive outreach, community-based recovery resource development, linkage to indigenous recovery supports in the community. The core functions of the addiction counselor narrowed (screen, assess, diagnose, treat/counsel, document, discharge), and substantial state and federal resources were invested in skill development related to these core functions. The professionalization of addiction counseling was also marked by the rise of national and state associations for addiction counselors, the development of certification and licensing standards for addiction professionals (with increased educational requirements), the proliferation of preparatory addictions studies programs in colleges and universities, new resources for continuing education, and improved salaries and benefits for addiction counselors.

The 1970s and 1980s marked the transition of the addiction counselor from the status of paraprofessional to that of a clinical professional on par with other recognized helping roles. Rarely noticed during this period of explosive growth was the decline in recovery representation in the addiction treatment workforce and among executive leadership and governing boards, the erosion of once strong volunteer and alumni programs, weakened connections to local communities of recovery, and a shift in orientation from long-term recovery to ever-briefer periods of treatment. Cyclical episodes of biopsychosocial stabilization became the norm with a growing portion of persons entering treatment with multiple prior admissions. There was throughout the 1990s a sense of great pride in how far the field of addiction treatment had come in a few short decades, but there was also underlying unease that things of great value had been lost in the professionalization, industrialization, and commercialization of addiction treatment (White, 2000b).

The recovery advocates of the 1940s-1960s spent much of their lives advocating for the federal legislation that in the early 1970s established the foundation of modern addiction treatment. They did so in the belief that specialized addiction treatment could provide a portal of entry into recovery for people who could not otherwise initiate or sustain recovery. By the mid1990s, there was a growing sense among a new generation of recovery advocates and many longtenured addiction counselors that the multibillion dollar addiction treatment industry had become disconnected from the larger and more enduring process of addiction recovery and from the grassroots communities whose efforts had had birthed the field (Else, 1999; Morgan, 1995; White, 2002, 2004).

Recovery Renewal

Several contextual conditions set the stage for calls to renew long-term recovery as the central mission of addiction treatment and addiction counseling: the growth and diversification of recovery mutual aid organizations, a new recovery advocacy movement that both supported addiction treatment and challenged its diminished recovery orientation, the emergence of new recovery support institutions as adjuncts and alternatives to addiction treatment, a growing body of research findings on the limitations of the acute care model of addiction treatment, the reconceptualization of addiction as a chronic disorder, and increasing calls to shift treatment of the most severe and complex AOD problems toward a model of sustained recovery management (Dennis & Scott, 2007; Kelly & White, 2011; McLellan, Lewis, O'Brien, & Kleber, 2000; White, 2005, 2008a,b,d; White, Kelly, &

Roth, in press; White & McLellan, 2008). It was perhaps inevitable in the face of such changes that the field's organizing center began to slowly shift from its historical focus on addiction pathology and the mechanics of treatment to rising interest in the prevalence, pathways, and processes of long-term personal and family recovery.

Fulfilling the vision of recovery-focused addiction treatment and addiction counseling will require substantial changes in the field's infrastructure (McLellan, Carise, & Kleber, 2003), service practices (White, 2008c), and evaluation methodologies (McLellan, 2002):

- Recovery-oriented addiction treatment/ counseling will require authentic and diverse personal/family recovery representation at all levels of decision-making within the addictions field.
- Major efforts at workforce stabilization and recovery-focused education and training of addiction professionals will need to be undertaken to ensure that each individual/family seeking help will have continuity of contact in a primary recovery support relationship over the course of long-term recovery.
- The diverse pathways and styles of long-term addiction recovery will need to be carefully mapped, and addiction professionals will need to be knowledgeable of the growing varieties of recovery experience and recovery cultures.
- Recovery-focused addiction counseling would extend the goal of acute biopsychosocial stabilization to encompass pre-treatment recovery priming (assertive outreach and engagement) and support for post-stabilization transitions to recovery maintenance, enhanced quality of life in long-term recovery, and family-centered interventions to break intergenerational cycles of problem transmission.
- Patients/families seeking addiction treatment would be routinely informed of independently verified, program and modality specific recovery outcomes (remission and survival rates) as well as the frequency of iatrogenic risks (harmful sideeffects)—in the same way patients are today informed of such risks in life-invasive medical procedures for the treatment of cancer or heart disease.
- Recovery-focused assessment activities would move beyond assessment of individual addiction pathology as an intake activity to comprehensive (using global assessment instruments), strengths-based (focusing on the evaluation of personal, family, and community recovery capital) and continual assessment activities.
- Individuals and families once channeled into pre-packaged "programs" would have access to an ever-expanding menu of recovery-focused, science-grounded services/supports—including a broad spectrum of primary and behavioral health care services—that would be personally matched, combined, sequenced, and adequately dosed to maximize their effects on successful recovery initiation and long-term maintenance.
- Multi-disciplinary, multi-agency service models with inclusion of culturally indigenous institutions and healers would become the norm for treating the most severe substance use disorders.
- The service relationship would shift from an expert model toward a partnership model of long-term recovery support.
- The emphasis on professionally-directed treatment planning would be extended to person-directed recovery planning—both processes guided by personal/family choice (White, 2008e) with interim outcomes carefully monitored and communicated to inform continued

treatment and recovery support decisions (McLellan, McKay, Forman, Cacciola, & Kemp, 2005).

- The locus of service delivery for addiction professionals would be extended far beyond specialty sector addiction treatment programs, with addiction professionals working within a broad spectrum of healthcare, educational, business, military, religious, social service, sports, and media settings. Great emphasis would be placed on reaching and serving people within their natural environments using both face-toface and technology-facilitated support.
- Aftercare as an afterthought in addiction treatment would give way to an emphasis on sustained post-treatment recovery checkups (for at least 5 years for everyone admitted to addiction treatment regardless of discharge status), stage-appropriate recovery education, assertive linkage to recovery mutual aid groups and other indigenous recovery support institutions, and if and when needed, early re-intervention (Dennis & Scott, 2012).
- The distinctive clinical orientation of addiction counselors would be expanded to cover community assessment and recovery resource development and mobilization (White, 2009a). Some addiction professionals would work in specialized roles aimed at the expansion of family and community recovery capital and building bridges of collaboration between professional addiction treatment organizations and the growing networks of recovery mutual aid organizations and other recovery support institutions.

Efforts to increase the recovery orientation of addiction treatment/counseling are underway across the United States under the conceptual rubrics of recovery management and recovery-oriented systems of care. The success or failure of these efforts will exert a powerful influence on the future of addiction recovery in America and the fate of specialty-sector addiction treatment as a cultural institution.

References

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Crothers, T. D. (1897). Reformed men as asylum managers. *Quarterly Journal of Inebriety*, *19*, 79.

Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

Dennis, M. L., & Scott, C. K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence*, *121*, 10-17. doi: 10.1016/j.drugalcdep.2011.07.026

Else, J. D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery,* *6*(2), 11-23. doi:10.1300/J048v06n02_02

Kelly, J. F., & White, W. L. (Eds., 2011). *Addiction recovery management: Theory, science and practice*. New York: Springer Science.

McLellan, A. T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, *97*, 249-252. doi:10.1046/j.1360-0443.2002.00127.x

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse*

Treatment, *25*, 117-121. doi:10.1016/S0740-5472(03)00156-9

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. doi:10.1001/jama.284.13.1689

McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction*, *100*, 447-458. doi:10.1111/j.1360-0443.2005.01012.x

Morgan, O. J. (1995). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly*, *12*(1), 59-71. doi:10.1300/J020v12n01_05

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. L. (1999). The first addiction counselors. *Counselor, 17*(5), 8-10.

White, W. L. (2000a). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, *18*(1), 1-23. doi:10.1300/J020v18n01_01

White, W. L. (2000b). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly, 18*(2), 1-25. doi:10.1300/J020v18n02_01

White, W. L. (2002). The treatment renewal movement. *Counselor, 3*(1), 59-61.

White, W. L. (2004). Recovery: The next frontier. *Counselor*, *5*(1), 18-21.

White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 315. doi:10.1300/J020v23n01_02

White, W. L. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care* (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. L. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. L. (2008c). *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. L. (2008d). The culture of recovery in America: Recent developments and their significance. *Counselor*, *9*(4), 44-51.

White, W. L. (2008e). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

White, W. L. (2009a). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158. doi:10.1016/j.jsat.208.10.006

White, W. (2009b). *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center

and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L., Kelly, J., & Roth, J. (in press). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, *7*(2-3).

White, W. L., & McLellan, A. T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, *9*(3), 24-33.



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. (2012). Is it time we became recovery professionals? Posted at **www.williamwhitepapers.com**

Commentary
Is It Time We Became Recovery Professionals?

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

More than four decades ago, I decided to spend my life helping people recovery from alcohol and other drug (AOD) addictions. The subsequent years working in this unusual avocation have been filled with blessings beyond what I could have imagined as a young man. Yet in reflecting on my years in addiction counseling and the broader arena of addiction treatment and research, there seems to have been something missing within the organizing center of our field. This missed dimension is evident in both how addiction counselors (and other specialized addiction-related professionals) are trained and how we have defined ourselves. Put simply, our growing knowledge and expertise in the intricacies of AOD problem and the nuances of ever-briefer interventions into those problems has left little room for developing knowledge and expertise in the long-term solutions we seek.

Most of us are thrown so rapidly into the daily demands of working in addiction treatment that we quickly lose our capacity to see—really SEE—the field's central focus or changes in that focus over time. In this short essay, I ask that you step back from such demands and look afresh at the field, not through the lens of addiction or the lens of addiction counseling/treatment but through the lens of long-term addiction recovery.

As part of our training, we are taught the pharmacology of alcohol and other psychoactive drugs, including the acute and chronic effects of excessive use. We are not taught which of these effects remit with sustained abstinence, when such remission of effects normally occurs, which effects may constitute a burden carried for years into the recovery process, and how such longer-term or permanent impairments and risks can be managed within the recovery process.

We are regularly provided detailed statistical tables of the latest drug use prevalence trends with recent changes in these patterns meticulously plotted against decades of past surveys. What we are not taught is the prevalence of long-term recovery in the United States and how this has changed over time, nor are we privy to the evolution of annual rates of recovery initiation. Are there more people in recovery in the U.S. and in your state today than a year ago? Did more people enter recovery this year than last year? We simply don't

know. Detailed profiles of those with alcohol and other drug problems are pervasive, but glaring by their omission are the demographic and health profiles of individuals and families in addiction recovery.

We are taught how to define addiction, the inclusion and exclusion criteria for a whole menu of substance use disorders as well as nuanced understandings of varying patterns of problem severity, complexity and chronicity. We are not taught a similarly uniform definition of recovery nor are we provided in-depth training on the multiple pathways and styles of long-term addiction recovery. We are taught what science and clinical practice reveal about problem progression and the late stages of addiction, but we are not taught the course and stages of long-term personal and family recovery.

We are taught the genetics and neurobiology of addiction as a brain disease with unending slides of drug-hijacked brains and promises that promotion of the brain disease model will reduce stigma, but we are not told how this very model could inadvertently increase stigma and discrimination. We are not taught the neurobiology of recovery (the likelihood of such recovery, the mechanisms of such recovery and when such recovery can be expected to occur). Nor are we taught how to answer a client's most basic questions about the personal implications of addiction-related genetic research: 1) Are all of my children higher risk for addiction because of my personal and family history? 2) Will my recovery status or failure to recovery affect my children's vulnerability or their chances of recovery if they should experience addiction? 3) Is there anything I can do as a parent to reduce these elevated risks for my children?

We know a great deal about how to facilitate acute biopsychosocial stabilization for people seeking addiction treatment, but we know very little about the transition to recovery maintenance and the stages of recovery that follow. We know a lot about the effects of addiction on the family and its members, but little about how to build the support scaffolding that can prepare the family for what Dr. Stephanie Brown has christened the "trauma of recovery"—a trauma whose greatest effects are seen after treatment professionals have terminated their brief service relationships..

We are trained in the basic treatment modalities of addiction treatment and a wide spectrum of counseling techniques, but we learn little about the role of community in recovery, the role indigenous helpers can play in recovery initiation and maintenance and how we can best collaborate with these recovery support resources. We know a great deal about how to counsel individuals in the earliest days of recovery but very little about how to counselor individuals and families with years or decades of recovery.

In recent years we have access to a robust body of information on AOD problems among historically disempowered populations (women, youth, ethnic and sexual minorities, persons with co-occurring (and often equally stigmatized conditions), but we are far less likely to learn about how such populations have resisted and recovered from these problems. For example, AOD problems in Native American and African American communities are visibly portrayed in the public and professional media, but the high rates of recovery and the recovery stories from these communities are missing from public reports and from the training of addiction counselors.

We are taught the laws, regulations, ethics and etiquette governing our profession while neglecting the very thing for which all of these exist. Without connection to long-term recovery as a measurable outcome, what value are any of these professional trappings?

We are taught to look to the "addiction studies" programs; "addiction medicine" specialists; national offices, institutes and centers on "Drug Control Policy," "Alcohol Abuse and Alcoholism," "Drug Abuse" and "Substance Abuse Treatment"; and regional "Addiction Technology Transfer Centers," but there are no "recovery studies" programs, no "recovery medicine specialists," no offices, institutes or centers

on “recover” and no “recovery technology transfer centers.” We have journals of alcohol and drug studies, psychoactive drugs, substance misuse, addiction, addictive behavior, addiction research and theory, alcohol and drug dependence, alcoholism treatment, and substance abuse treatment, to name a few, but only one (*Journal of Groups in Addiction and Recovery*) that even suggests by its title an interest in the scientific study of recovery. Experts and resources abound on alcohol and other drug problems and their acute treatment. Where are the professional experts and professional resources on the long-term solutions to these problems?

If we examined the curricula of addiction studies programs in the United States, the content of certification and licensing exams required to work in addiction counseling and the topical content of continuing education programs for addiction counselors, what percentage of that content would we find focused the subject of recovery? We escaped the brand of “paraprofessional.” We evolved from seeing ourselves as addiction professionals to seeing ourselves as treatment professionals. Perhaps it is time we become recovery professionals.

About the Author: William White is a Senior Research Consultant at Chestnut Health Systems. His collected papers are posted at www.williamwhitepapers.com

The 2012 Recovery Parade in Japan

Introduction

In 2007, I was invited to visit a number of addiction treatment and recovery centers in Japan and to deliver lectures on the new recovery advocacy movement in the United States. My description of early U.S. recovery celebration events and the images I showed of people in recovery and their families marching to celebrate recovery on the streets of major American cities drew much interest from my Japanese audiences. Upon my return, I continued correspondence with many of my new friends in recovery from Japan and was delighted when the announcement arrived of the first public recovery celebration parade in Tokyo in 2010. The report (prepared by Andy Graham) and images below were sent to me by Isamu Shiroma with a request that they be shared with recovery advocates in the United States. I hope you will be as inspired by them as I was.

William White, November 2012

The 2012 Recovery Parade in Japan

The third annual Recovery Parade in Tokyo was held on September 23, 2012. Alas, the gods declined to smile down upon us. As on the day of the first recovery parade in 2010, it was raining. But the happy alcoholics and others in recovery, together with family members, friends, and supporters, refused to let that deter them. Gathering at the appropriately named Plaza of Water in Shinjuku Central Park at 12:30 pm, we headed out shortly before 1:00, wending our way through the streets of Shinjuku, one of the busiest spots in central Tokyo, singing as we walked along. With our faces and voices, we conveyed a message of hope and joy to all who caught sight of our procession. And we all had a good time.

After the event, the Recovery Parade Executive Committee posted the following message of thanks on the Japanese and English website at http://recoveryparade-japan.com/:

> We are pleased to report that the Third Recovery Parade took place without problem on September 21, 2012 (Sunday).
>
> Despite the inclement weather, about 300 people took part in the event. And on the day before that, the first Recovery Parade in Hiroshima took place, also with about 300 participants.
>
> We wish to extend our heartfelt thanks to all the individuals and organizations who cooperated with and endorsed our activities during the past year, as well as supporting us with financial contributions.
>
> Already preparations have begun for the fourth parade. We are eagerly awaiting the day one year from now when we will be able to meet you once again. Let us all gather together for number four. Thank you very much.
>
> Yuji Sato
> Chairman, Executive Committee
> Recovery Parade & "Recovery Festival


回復の祭典
リカバリー・パレード


心の病からの回復


心の病からの回復


心の病からの回復






酒運転
やめよう


続けることでしか
続けられない


PEPSI



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., Kelly, J. & Roth, J. (2012). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. Journal of Groups in Addiction & Recovery, 7(2-4), 297-317. Posted at **www.williamwhitepapers.com**

New Addiction Recovery Support Institutions: Mobilizing Support beyond Professional Addiction Treatment and Recovery Mutual Aid

William L. White, MA, John F. Kelly, PhD, and Jeffrey D. Roth, MD

Abstract

For more than 150 years, support for the personal resolution of severe and persistent alcohol and other drug problems in the United States has been provided through three mechanisms: family, kinship, and informal social networks; peer-based recovery mutual aid societies; and professionally directed addiction treatment. This article: 1) briefly reviews the history of these traditional recovery supports, 2) describes the recent emergence of new recovery support institutions and a distinctive, all-inclusive culture of recovery, and 3) discusses the implications of these recent developments for the future of addiction treatment and recovery in the United States.

Keywords: Recovery mutual aid, recovery community organizations, recovery advocacy movement, recovery homes, recovery industries, recovery schools, recovery ministries, culture of recovery

Introduction

There is growing evidence that the central organizing construct guiding addiction treatment and the larger alcohol and other drug (AOD) problems arena is shifting from long-standing pathology and intervention paradigms toward a solution-focused recovery paradigm (El-Guebaly, 2012; Laudet, 2008; White, 2008a). Calls are increasing to extend the prevailing acute care model of addiction treatment to a model of sustained recovery management (Dennis & Scott, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000) and to nest these expanded treatment and support models within larger recovery-oriented systems of care (Kelly & White, 2011; White, 2008b). Related trends include increased interests in defining recovery (Betty Ford Institute Consensus Panel, 2007); evaluating the effects of participation in recovery mutual aid societies on long-term personal recovery and social cost outcomes (Humphreys et al., 2004; Kelly & Yeterian, 2008); identifying effective linkage procedures between addiction treatment and recovery mutual aid societies (Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009; White &

Kurtz, 2006); and expanding access to new forms of peer-based recovery support services (White, 2009b). There is also heightened interest in post-treatment recovery support mechanisms (McKay, 2009) for adults (Dennis & Scott, 2012) and for adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2007). This latter trend is encouraging, particularly in light of the contention that recovery-focused "systems transformation" efforts that only focus on professional treatment and mutual aid miss opportunities to develop and mobilize broader addiction recovery support resources within the community (White, 2009b).

Cloud and Granfield (2008) introduced the term *recovery capital* to designate the collective internal and external resources that can be mobilized to initiate and sustain the resolution of AOD problems at a personal level. Traditionally, recovery capital exists as a continuum of assets within three distinct spheres: 1) support from family, kinship, and social networks; 2) generalized support from indigenous cultural institutions (e.g., the arenas of medicine, business, education, religion, and social welfare); and 3) the more specialized support provided by addiction recovery mutual aid groups and professionally directed addiction treatment. For more than 150 years, these latter specialized addiction recovery resources have provided the major help for persons with the most severe, complex, and prolonged AOD problems. There are, however, newly emerging addiction recovery support institutions that do not fit within the addiction recovery mutual aid or addiction treatment dichotomy.

This paper is an exercise in "connecting the dots" between what have been viewed as discreet developments to tell a larger story with potentially profound historical significance. The authors will: 1) briefly review the history of traditional recovery support structures in the United States, 2) describe the recent emergence of new recovery support institutions and an increasingly vibrant culture of recovery beyond the arenas of addiction treatment and recovery mutual aid, and 3) discuss how these developments could affect the future of addiction treatment and recovery.[1]

The History of Traditional Recovery Support Structures

Sophisticated epidemiological surveys and large scale clinical studies have triggered debates on whether AOD problems are self-regulating and self-limiting (as suggested by the former) or whether they require professional intervention and long-term care (as suggested by the latter). There is an extensive body of research on the phenomenon of "natural recovery"—the resolution of AOD problems without participation in addiction treatment or recovery mutual aid groups (Cunningham, 1999; Roizen, Cahalan, & Shanks, 1978; Sobell, Cunningham, & Sobell, 1996). This style of recovery is also reflected in a literary tradition of recovery memoirs within which people cast off AOD problems through a spectrum of religious, spiritual, and secular experiences outside the context of professional treatment or organized recovery support societies (For a review of early U.S. memoirs, see White, 2000). Even today, one does not have to travel far to find individuals who claim to have shed these problems without doing "rehab" or "meetings."

Recent community surveys revealing that most people (as many as 75%) who resolve AOD-related problems do so without formal treatment or mutual aid involvement (Dawson, 1996; Lopez-Quintero et al., 2010; Schutte, Moos, & Brennan, 2006). This finding may be disconcerting to addiction professionals who spend their lives caring for those with the most severe, complex, and chronic AOD problems and who tend to see all AOD problems as progressive, chronically relapsing disorders resolved only through professional treatment and/or sustained involvement in a recovery mutual aid society. In contrast, those who study the trajectory of AOD problems in larger community populations have come to expect that such problems are self-limiting (rather

[1] All historical events and trends not otherwise cited are abstracted from White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

than progressive) and resolvable through one's natural resources. The former perspective has been referred to as the "clinician's illusion" (Cohen & Cohen, 1984) and the latter as the "epidemiologist's illusion" (Moos & Finney, 2011).

Neither perspective, in isolation, fully encompasses the two overlapping worlds of AOD problems or adequately explains the marked differences between the course of AOD problems in clinical and community populations (Storbjork, & Room, 2008). The ability to resolve AOD problems across these populations seems to depend on the interaction between differing levels of personal/family/community recovery capital and different degrees of personal vulnerability and problem severity/complexity/chronicity (See White, 2008b for review).

The role external resources play in the resolution of AOD problems in clinical and community populations raises two interesting questions that set the stage for our continued discussions.

1. *Within the general population, could focused and sustained efforts to expand recovery support resources beyond addiction treatment and recovery mutual aid increase the prevalence of natural recovery from a broad spectrum of AOD problems?*
2. *Within clinical populations, could development of an expanded menu of community-based recovery support services be combined with addiction treatment and/or participation in recovery mutual aid to increase rates of successful recovery initiation and maintenance—particularly among those with the most severe substance use disorders?*

A Brief History of U.S. Addiction Recovery Treatment and Mutual Aid

The story of addiction recovery mutual aid in the United States begins with the rise of abstinence-based religious and cultural revitalization movements among Native American tribes (e.g., the Handsome Lake Movement [1799]; the Shawnee Prophet Movement [1805]). This tradition of culturally nuanced mutual support organized by and for people in addiction recovery continued in Native communities through subsequent religious and cultural revitalization movements, including the subsequent "Indianization of AA," the Red Road, and the contemporary Wellbriety Movement (Coyhis & White, 2006).

Organized mutual support for recovery in Euro-American communities began with people with alcohol problems seeking sanctuary within newly forming temperance societies (1830s) and extends through the more exclusive recovery-focused groups such as the Washingtonians (1840), recovery-focused temperance societies (1840s-1850s), Dashaway Association (1859), the Ribbon Reform Clubs (1870s), and the Drunkard's Club (1871). These early efforts encompassed both secular and explicitly religious as well as abstinence-based and moderation-based frameworks of recovery (White, 1998, 2001a).

Following the collapse of the first wave of alcoholism recovery mutual aid groups, new transition groups, such as the Brotherhood of St. Luke (1904), the Jacoby Club (1910), and the United Order of Ex-Boozers (1914), set the stage for the founding of Alcoholics Anonymous (AA, 1935), the first efforts to adapt AA for narcotic addicts (Addicts Anonymous, 1947; Habit Forming Drugs, 1951; Hypes and Alcoholics, early 1950s), the founding of Narcotics Anonymous (NA) in New York City (1948), and the birth of NA as it is known today on the West Coast (1953, White, 2011).

In the years that followed, specialty groups branched from AA (e.g., the Calix Society [1947]; Al-Anon [1951]; Alateen [1957]), and AA's Twelve Steps were adapted for people dependent on other drugs—Potsmokers Anonymous (1968), Pills Anonymous (1975), Marijuana Anonymous (1989), Cocaine Anonymous (1982), Nicotine Anonymous (1985)—and for persons with co-occurring disorders (e.g., Dual Disorders Anonymous [1982], Dual Recovery Anonymous [1989], and Double Trouble in Recovery, [1993], White, 2011).

The latest phase in this history is the diversification of recovery mutual aid with the growth of secular and religious alternatives to Twelve-Step programs (e.g., Women for Sobriety [1975], American Atheists Alcohol Recovery Group [1980], Secular Organization for Sobriety/Save Our Selves [1985], Rational Recovery [1986], Smart Recovery® [1994], Moderation Management [1994], and LifeRing Secular Recovery [1999]). Explicitly religious recovery support groups also emerged (e.g., Alcoholics Victorious [1948], Alcoholics for Christ [1977], Overcomers Outreach [1977], Liontamers Anonymous [1980], Millati Islami [1989], and the Buddhist Recovery Network [2008], White, 1998, 2011).

Most recovery mutual aid organizations, perhaps because of the stigma attached to AOD problems, have operated as closed, self-contained organizations, but there are exceptions. There is a long history of social clubhouses spawned by mutual aid members. Clubhouses operate independently but in close tandem with their mutual aid organizations. Mutual aid organizations have also been involved in creating treatment organizations—from detoxification beds set up in the upstairs of Washingtonian Hall (in the 1840s) to AA co-founder Bill Wilson's vision of AA hospitals and AA missionaries. Recovery organizations have also been spawned inside addiction treatment organizations, including the Ollapod Club (1868), the Godwin Association (1872), and the Keeley Leagues (1891). The boundary between mutual aid and treatment has not always been a clear one.

Marking the early roots of today's specialty sector treatment system, an elaborate network of inebriate homes, medically directed inebriate asylums, private for-profit addiction cure institutes, and proprietary home cures for addiction flourished in the second half of the 19th century. These treatments, along with their mutual aid counterparts, collapsed in the opening decades of the 20th century in the wake of alcohol and drug prohibition movements. Following this collapse, cultural authority for the control of those with severe AOD problems passed to the criminal justice system (e.g., inebriate penal colonies, federal prisons), to the emergency rooms and "foul wards" of large public hospitals, and to the "back wards" of aging state psychiatric asylums. Compassion and care gave way to sequestration, punishment, and control (White, 1998).

The resurgence of a vibrant, specialized addiction treatment field required decades of assertive advocacy and the development of replicable models of treatment between 1940 and 1965 (e.g., social setting detoxification, outpatient alcoholism clinics, residential models of alcoholism treatment, therapeutic communities, methadone maintenance, outpatient drug-free counseling clinics). Landmark legislation in the early 1970s set the stage for the rise of modern addiction treatment as a specialized health care field. The federal, state, and local partnership framed within this legislation and the subsequent extension of insurance coverage for the treatment of addiction led to the growth of specialized addiction treatment from a few hundred small programs to more than 15,000 institutions with a daily treatment capacity or more than 1.75 million patients served by a workforce of 130,000 full-time and 67,000 part-time and contractual workers (Kaplan, 2003; McLellan, Carise, & Kleber, 2003; SAMHSA, 2011).

This history has been presented elsewhere in far greater detail (White, 1998), but four themes within this history are pertinent to the current discussion. First, in spite of divergent philosophies and methods of care, the primary and almost exclusive unit of intervention within addiction treatment has been the *individual*—not the family, kinship network, or the larger natural environment in which recovery is sustained or extinguished.

Second, the primary model of addiction treatment delivery mimics the acute care (AC) hospital with its functions of screening, admission, assessment, brief (and ever-briefer) treatment, discharge, and termination of the service relationship. Early critics of this AC model of addiction treatment characterized it as a mechanistic, expensive illusion, disconnected from the processes of long-term recovery (Dodd, 1997). Later critiques focused on weaknesses of the AC model related to attraction, access, retention, inadequate service dose, low utilization of evidence-based clinical practices, weak linkage to communities of recovery, the absence of post-

treatment monitoring and support, and high rates of re-addiction and re-admission (Kelly & White, 2011; White, 2008b).

Third, the methods of treatment were distinctly clinical in their orientation (e.g., professional roles and interventions adapted from the fields of psychiatry, psychology, and psychiatric social work), with a particular focus on biopsychosocial stabilization. Intervention models that focused on recovery community resource development and assertive linkage to community recovery support systems were briefly considered in the 1960s and early 1970s but rapidly gave way to more medicalized models of care and the subsequent professionalization and commercialization of addiction treatment (White, 2002). As a result, non-professional recovery resources in the local community came to be seen as an adjunct to treatment—an afterthought to the more important intrapersonal clinical work—as opposed to treatment being viewed as an adjunct to more accessible and enduring recovery maintenance resources in the community. Few modern programs defined their role as a catalyst for the development of non-clinical recovery support resources in the communities they served, in great part because such activities were not reimbursable within prevailing AC models of care.

There have been efforts to break out of these encapsulated categories of recovery mutual aid and clinically directed addiction treatment. The halfway house movement of the 1950s sought a connecting bridge between these two worlds and to the larger process of community reintegration (Rubington, 1967); the Minnesota Model programs sought to blend these worlds within a treatment milieu (Spicer, 1993); the social model of recovery pioneered in California provided a distinct alternative to clinical treatment (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Shaw & Borkman, 1990/1991); and early therapeutic communities existed as cultures of their own isolated from both mainstream addiction treatment and mainstream recovery mutual aid groups (Janzen, 2001). In spite of such exceptions, professionally directed addiction treatment and recovery mutual aid groups have remained, until recently, the primary specialized recovery support institutions.

New Addiction Recovery Support Institutions

The self-containment of recovery mutual aid organizations and the similar self-containment and isolation of the addiction treatment enterprise has created a void of unmet need in the larger community for a broader spectrum of recovery support resources. That need is being filled in part by the rise of new recovery support institutions and a broader culture of recovery.

New Addiction Recovery Advocacy Movement: In the late 1990s, new grassroots recovery community organizations (RCOs) began dotting the American landscape, stimulated in part by the Center for Substance Abuse Treatment's Recovery Community Support Program that in 1998 began providing seed money for such organizations (Kaplan, Nugent, Baker & Clark, 2010). RCOs are organized by and on behalf of people in recovery and participate in a wide variety of recovery advocacy and peer recovery support activities. In 2004, the White House-initiated Access to Recovery program also began providing grants to states and tribal organizations for peer and other recovery support services.

In 2001, RCO representatives from around the country met in St. Paul, Minnesota, to launch what has since been christened the new addiction recovery advocacy movement. The 2001 meeting brought together local RCOs and existing national advocacy organizations such as the National Council on Alcoholism and Drug Dependence (NCADD), the Johnson Institute's Alliance Project, and the Legal Action Center. A new organization, Faces and Voices of Recovery, was created at the summit that has since provided the connecting tissue for RCOs across the U.S. and beyond. In 2011, these RCOs formed the Association of Recovery Community Organizations (White, 2006).

The goals of what is rapidly becoming an international recovery advocacy movement (Roth, 2010) include: 1) the political and cultural mobilization of communities of recovery, 2)

recovery-focused public and professional education, 3) advocacy of pro-recovery laws and social policies, 4) advocacy for a recovery-focused redesign of addiction treatment, 5) promotion of peer-based recovery support services, 6) support for international, national, state, and local recovery celebration events, and 7) promotion of a recovery research agenda (White, 2007). The movement's core organizing themes are displayed in Table 1.

Table 1: Kinetic Ideas of the New Addiction Recovery Advocacy Movement
1. Addiction recovery is a reality in the lives of millions of individuals, families, and communities. 2. There are many paths to recovery—and all are cause for celebration. 3. Recovery flourishes in supportive communities. 4. Recovery is a voluntary process. 5. Recovering and recovered people are part of the solution; recovery gives back what addiction has taken—from individuals, families, and communities (White, 2006).

As a point of perspective, in 1976, 52 prominent Americans publicly announced their long-term recovery from alcoholism as part of the National Council of Alcoholism's Operation Understanding—an anti-stigma campaign aimed at challenging stereotypes about alcoholism. It was the largest public "coming out" of people in recovery in the twentieth century. In September 2011, more than 100,000 people in recovery and their families, friends, and allies participated in more than 200 public Recovery Month celebration events across the United States. That magnitude of cultural and political mobilization of people in recovery is historically unprecedented. The present recovery advocacy movement is distinctive in its explicit focus on eliminating policy barriers to addiction recovery and promoting a policy environment in which addiction recovery can flourish.

Recovery Community Centers (RCCs): Many RCOs are creating local recovery community centers, and some states (e.g., Connecticut, Vermont, Rhode Island) have created regional networks of RCCs. RCCs host recovery support meetings; provide recovery coaching; provide linkage to a wide spectrum of resources including recovery housing and recovery-conducive education and employment; serve as a site for recovery-focused social networking; and serve as a central hub for advocacy, peer support, and community service activities. In a recent year, for example, Vermont's nine recovery community centers, with just 15 part-time staff and 150 volunteers (30,000 hours of volunteer support per year), were open 70 hours per week, hosted 127 recovery support meetings per week, and had a total of 143,903 visits—25% of whom had less than a year of recovery, and 33% of whom had never participated in addiction treatment (White, 2009b).

Recovery Homes: Recovery residences are distinguished from addiction treatment by their homelike environment, self-determined lengths of stay, democratic self-governance, and their reliance on experiential rather than professional authority—no paid professional staff. The majority of recovery homes are financially self-supported by the residents. Most visible among the recovery residence network is Oxford House. Founded in 1975, Oxford House has grown to include more than 1,500 recovery homes in 48 states (432 cities) with a collective annual occupancy of more than 24,000 recovering people (Molloy & White, 2009; Oxford House Inc. Annual Report, 2011).

Jason and colleagues have conducted extensive studies of Oxford House and have found that the prospects of long-term recovery rise with length of stay (Jason, Davis, & Ferrari, 2007; Jason, Olson, Ferrari, & Lo Sasso, 2006; Jason et al., 2007). These outcomes extend to women, racial and ethnic minorities, and people with co-occurring psychiatric disorders (d'Arlach, Olson, Jason, & Ferrari, 2006; Ferrari, Curtin-Davis, Dvorchak, & Jason, 1997; Majer et al., 2008).

Indicative of the spread of recovery homes, a recent survey in Philadelphia identified 21 city-funded recovery residences (primarily for persons re-entering the community from the criminal justice system) and a larger network of 250 financially self-supported recovery homes (Johnson, Martin, Sheahan, Way, & White, 2009). In 2011, representatives from the growing national network of recovery homes founded the National Association of Recovery Residences toward the aims of assuring the quality of recovery residences and linking them into a more integrated network of long-term recovery support.

Recovery Schools: People in recovery face great obstacles in entering or returning to secondary and post-secondary schools—settings that have been characterized as "abstinence-hostile environments" (Cleveland, Harris, Baker, Herbert, & Dean, 2007). A broad spectrum of programs, collectively embraced within the rubric of the "recovery school movement," has emerged to provide recovery support within the academic environment (Roth & Finch, 2010). Beginning with Brown University, Rutgers University, Texas Tech University, and Augsburg College, specialized campus-based recovery support programs have provided an array of recovery supports ranging from scholarships for students in recovery, sober housing, on-campus recovery support groups, recovery coaching, academic mentoring, study groups, sober social activities, and community service projects. Since Ecole Nouvelle (now Sobriety High) in Minnesota was opened in 1986, there has been a similar growth in the development of recovery high schools. Twenty-five recovery high schools opened across the United States between 1999 and 2005 (White & Finch, 2006).

Studies to date of school-based recovery support programs confirm high rates of uninterrupted abstinence (70-80%), early intervention and retention of students following any AOD use, excellent academic performance, high class attendance rates (90-95%), high graduation rates, and high rates (65%) of college attendance among students in recovery high schools (Botzet, Winters, & Fahnhorst, 2007; Cleveland et al., 2007; Gibson, 1991; Harris, Baker, Kimball, & Shumway, 2007; Moberg & Finch, 2007; White, 2001b). The growth of school-based programs led to the formation in 2002 of the Association of Recovery Schools.

Recovery Industries: Although obtaining meaningful, recovery-conducive work is a significant challenge for many people entering recovery within the current economic climate, vocational counseling/training, assertive linkage to recovery-supportive employment, and job coaching are not standard components of modern specialty-sector addiction treatment in the United States (Magura, 2003; Room, 1998). Several recent community responses to employment needs of people in recovery are worthy of note. First, RCOs, often through their recovery community centers or recovery coaching projects, are establishing employment clearinghouses and incorporating work-related support into the recovery coaching process. Second, two specialized types of employment resources are emerging specifically for people in recovery entering or re-entering the workforce. The first consists of recovery-friendly employers who have had good experiences hiring people in recovery and who remain receptive to such hiring, particularly those in a structured recovery support process. Examples of such employers range from small businesses like Zingerman's Deli in Ann Arbor, Michigan, to large businesses such as Venturetech—a manufacturer of hydraulic pumps in Houston, Texas (See http://www.recoveryatwork.org/). The second type of specialized employment resource involves businesses established by people in recovery who exclusively employ people in recovery, e.g., Recovery at Work in Atlanta, Georgia; Business Enterprises in Portland, Oregon. In these settings, people in recovery have the opportunity to acquire work skills, establish a recent employment history, and work with and be supervised by other people in recovery as a pathway to continued employment at these sites or to develop a work history that increases opportunities for alternative employment opportunities (White, 2009b).

Recovery Ministries: Churches, mosques, synagogues, and temples have become increasingly involved in providing addiction recovery support services through the sponsorship of their respective faith communities. These efforts include recovery-friendly churches (e.g., Mercy Street in Houston, Texas), mega-churches with one or more "recovery pastors" (e.g.,

Saddleback Church in Southern California), lay leaders of church-sponsored recovery support groups (e.g., the spread of Celebrate Recovery in more than 10,000 churches), recovery-focused worship services and workshops, recovery churches (e.g., Central Park Recovery Church in St. Paul, MN), and faith-based recovery colonies (e.g., Dunklin Memorial Camp in Okeechobee, Florida, Swanson & McBean, 2011). One of the most well-known and enduring recovery ministries is that led by Reverend Cecil Williams at Glide Memorial Methodist Church in the Tenderloin District of San Francisco, California (Williams, 1992). Many of the Christian recovery ministries are linked and mutually supported through the National Association for Christian Recovery founded in 1989. The growth of recovery ministries has also spawned a support industry whose mission is to spread recovery ministries nationally and internationally, e.g., NET Institute (White, 2009b).

Recovery community organizations, recovery community centers, recovery residences, recovery schools, recovery industries, and recovery ministries share several distinctive features. First, these new recovery support institutions fit neither the designation of addiction treatment nor designation as a recovery mutual aid fellowship. Second, they provide recovery support needs not directly addressed through addiction treatment or recovery mutual aid societies. Third, their target of support extends beyond the individual. Where addiction treatment and mutual aid provide personal guidance during the recovery process, these new recovery support institutions seek to create a physical and social world, including a policy environment, in which personal and family recovery can flourish. Fourth, these new institutions reflect, and are in turn being shaped by, a larger culture of recovery that transcends association with any treatment or recovery mutual aid organization.

The Coming of Age of an American Culture of Recovery

The transition from addiction to recovery is a personal journey, but it can also involve a journey between two physical and social worlds—from a culture of addiction to a culture of recovery (White, 1996). Historically, this transition has been marked by shedding the trappings and folkways of the culture of addiction (language, values, symbols, rituals, relationships, dress, etc.) and replacing these with the cultural folkways of a particular treatment institution or recovery mutual aid society. What is significant today is the rise of a culture of recovery in the United States through a process of mutual identification that transcends where one's recovery started and the meetings one may or may not attend.

A broader cultural and political mobilization of people in recovery across diverse pathways and styles of recovery is emerging—a broader consciousness as *people in recovery*. People within particular recovery clans have been meeting in large numbers since the mass Washingtonian meetings of the 1840s, but people walking arm-in-arm on public streets in the U.S. representing an array of secular, spiritual, and recovery pathways and walking not as AA, NA, WFS, SOS, LifeRing, or Celebrate Recovery members but as "people in recovery" is historically unprecedented. With that breakthrough has come the rapid rise and maturation of what might be thought of as a "non-denominational" culture of recovery.

With this broadened sense of identity, previously marginalized individuals are undergoing processes of consciousness-raising, mobilization, and culture-making. This culture is providing a diverse menu of words, ideas, metaphors, rituals, support institutions, support roles, and recovery support services to ease the process of recovery initiation, recovery maintenance, and enhanced quality of life in long-term recovery. What recovering people historically experienced inside treatment or a recovery fellowship—connection, mutual identification, and community—is now being extended beyond the walls of these institutions and meeting rooms.

The extent to which a culture of recovery in the United States is emerging beyond the arenas of addiction treatment and recovery mutual aid is illustrated in Table 2.

Table 2: The Culture of Recovery in the United States: Emerging Elements and Representative Activities

Recovery Cultural Element	Representative Activities
Values	RCO identification of "recovery values" (e.g., primacy of personal recovery, singleness of purpose/mission fidelity, organizational transparency, honesty, humility, simplicity, respect, tolerance, inclusion, stewardship); Recovery Bill of Rights—Faces and Voices of Recovery.
History	History clubs, e.g., AA History Lovers; groups working on state/local recovery group histories; growing archivist movement within mutual aid groups; a book on the history of addiction recovery has gone through 10+ printings since 1998.
Language	Recovery-focused language audits; multiple advocacy papers on language challenging prevailing words and ideas (e.g., challenging the pervasive use of "abuse" within the AOD problems arena that have received recent research support, Kelly, Dow, & Westerhoff, 2011; Kelly & Westerhoff, 2010; White, 2006); Faces & Voices of Recovery Messaging Training.
Iconic Symbols	Recovery-themed posters, greeting cards, jewelry; the color amethyst (purple) used in t-shirts, posters, buttons, etc. from the Greek *amethystos*, meaning "not intoxicated"; and the butterfly, which symbolizes transition and rebirth.
Television	Recovery Television Network; increased recovery-themed cable television programming; heightened recovery-themed programming by the national networks; broader corporate sponsorship of recovery programming and activities.
Film	Recovery-themed documentaries and independent films, e.g., *The Secret World of Recovery*, *The Healing Power of Recovery*, *The Wellbriety Movement: Journey of Forgiveness*, *Lost in Woonsocket*, *Bill W*; growth in recovery film festivals.
Radio	Increased presence of recovery on conventional and Internet radio; Recovery Radio Network; Recovery 101 Radio; Recovery Coast-to Coast; Boston Recovery Radio; Afflicted and Affected; Recovery Matters; Steppin' Out Radio.
Theatre	Improbable Players in Watertown Square, MA; San Francisco Recovery Theatre; Phoenix Theatre Group (Helping Recovering Addicts via Art); The Vision Troupe (Bob LoBue's play *Visions*).
Music	Major recording artists expressing their recovery through music (e.g., Eminem, Mary J. Blige); Recovery Idol in Philadelphia, PA; the growing network of recovery music festivals—Sober in the Sun, Half Moon Sober Fest; Rockstar Superstar Project (Rebranding Sobriety).
Art	Recovery Murals in Philadelphia; growth of Recovery Fine Arts Festivals.
Literature	Recovery memoirs replacing drink/drug memoirs (Oksanen, 2012); papers and pamphlets related to recovery advocacy; annual recovery essay contests; recovery support for writers, e.g., Writers in Treatment.
Media Communications	Recovery lifestyle magazines—*Journey: A Magazine of Recovery*; *Recovery Living*, *Renew Magazine, Serene Scene Magazine*—and books; *Addictions and Answers: Dr. Dave and Bill*; *New York Daily News* column; growth in recovery blogs and sober lifestyle websites, e.g., http://www.thefix.com/content/blogs.

Comedy	Recovery comedians, e.g., Mark Lundholm, Tara Handron, Jessie Joyce; Laughs without Liquor—Recovery Comedy Tour.
Sports	Philadelphia's Clean Machine and Milwaukee's Rebound Basketball teams; Colorado-based Phoenix Multisport.
Social Clubs	Recovery clubhouses, Recovery Coffee Shop, Wichita, Kansas, and other coffee shops/cafes owned and operated by recovering people as recovery gathering sites; recovery dances; social events at recovery community centers.
Internet-based Social Networking	Recovery-focused social networking on My Space, Facebook, and Twitter; www.intherooms.com; www.addictiontribe.com; www.beatingaddiction.com; www.soberrecovery.com; www.sobercircle.com; http://myrecoveryspace.com/; http://www.cyberrecovery.net/forums/.
Travel	Recovery-focused travel, e.g., www.TravelSober.com; www.SoberCelebrations.com; www.SoberCruises.com; www.SoberTravelers.com.
Recovery Community Leadership Development	Faces & Voices of Recovery Leadership Academy; Recovery Corps, Baltimore, MD; training programs to prepare people to serve as recovery coaches, e.g., Connecticut Community of Addiction Recovery; McShin Foundation; recovering people participating in mapping community recovery resources (e.g., Philadelphia).
Community Service	Community Volunteer Corps, Portland, Oregon; Missouri Recovery Network's community cleanup projects.
Science	Participation in recovery-focused scientific research (e.g., National Quit and Recovery Registry); people in recovery participating in development of recovery measures with research scientist Lee Ann Kaskutas, PhD; people in recovery pursuing advanced education toward goal of conducting recovery research.
Recovery Advocacy Websites	www.facesandvoicesofrecovery.org (see for listing of RCOs across the country); www.recoveryiseverywhere.com; www.recoverymonth.gov.
National Recovery Celebration Events	Annual Rally for Recovery; Recovery Month events; America Honors Recovery Awards.
International Exchanges	U.K. recovery advocates visiting U.S. RCOs via Winston Churchill Scholarships; U.S. recovery advocates speaking at public recovery rallies in Europe, Asia, Africa, and South America.

This brief description does not adequately capture the growing sense of community experienced by people across pathways of recovery and the potential import of this trend to the future of recovery. The community-building process that is currently underway is comparable to that experienced at the height of the civil rights movement, the women's rights movement, and the LGBT rights movement. What remains to be seen are the limits of mutual identification and the boundaries of inclusion/exclusion within this emerging culture of recovery.

Implications of the New Support Institutions for Treatment, Mutual Aid, and the Enhancement of Recovery

For more than 150 years, addiction recovery support beyond the natural resources of family, extended family, and social networks and general support from mainstream social

institutions, has been provided by two specialized cultural institutions: addiction recovery mutual aid societies and professionally directed addiction treatment. In this paper, we have documented the emergence of new recovery support institutions (recovery community organizations, recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries) and a broader culture of recovery in the United States.

With the exception of the growing body of research on recovery residences, particularly the Oxford House network, and preliminary studies on collegiate recovery programs, little scientific attention has been directed toward investigating these new support mechanisms for addiction recovery. These new recovery supports also exist beyond the consciousness of the fields' clinical and policy leaders. The questions we pose below underscore our belief that the changes outlined in this paper constitute a significant milestone in the history of addiction recovery—a milestone that will have profound implications to the future study and treatment of alcohol and other drug problems.

Historical Identity and Cultural Status: How will new recovery support institutions affect the identities and cultural status of addiction recovery mutual aid groups and addiction treatment institutions and their respective claims of cultural ownership of AOD problems?

Utilization and Effectiveness of Existing Institutions: Will the spread of these new recovery support structures serve to increase rates of entrance, early retention, and continued participation in addiction treatment and formal recovery mutual aid groups? Will recovery rates within local addiction treatment and recovery mutual aid groups rise in tandem with the development of these broader recovery support institutions? Could addiction treatment organizations increase the long-term recovery outcomes of those they serve by taking a more assertive role in the development, support, and mobilization of indigenous community recovery support resources?

Natural Recovery: Will the prevalence of natural recovery—the resolution of AOD problems without participation in recovery mutual aid groups or professional treatment—increase under the influence and heightened accessibility of these new recovery support structures? Will new recovery support structures serve primarily as adjuncts or alternatives to addiction treatment and recovery mutual aid groups?

Active Ingredients: What are the similarities and differences in the active ingredients (elements that elevate long-term recovery outcomes) within new recovery support institutions compared to those within addiction treatment and recovery mutual aid groups?

Potent Combinations/Sequences: Are there particularly potent combinations or sequences of addiction treatment, recovery mutual aid, and participation in broader recovery support institutions that generate significantly higher rates of long-term recovery than could have been achieved through the use of each in isolation, e.g., combining outpatient treatment, mutual aid, and sober housing (Polcin, Korcha, Bond, & Galloway, 2010)?

Responses across Diverse Populations: Are there particular populations for whom participation in these broader recovery support institutions are indicated or contraindicated? Will new recovery support institutions reach ethnic group members with severe substance use disorders who currently underutilize addiction treatment and mainstream recovery mutual aid resources (Chartier & Caetano, 2011)?

The cultural management of AOD problems has historically focused on two targets: the individual and the community environment, with the activities of traditional recovery support institutions (i.e., professionally directed treatment and mutual aid organizations) focused almost exclusively on the individual. The trends outlined in this paper mark a movement into the chasm between the individual and the community. It is our expectation that greater attention will be given to improving recovery outcomes through strategies aimed at increasing *community recovery capital* (White & Cloud, 2008). This will involve a blending of traditional clinical strategies of intervention with strategies of cultural revitalization and community development. With that will come studies of the role of community recovery capital (including the emerging

resources described in this paper), as distinguished from the role of personal vulnerabilities and assets, in predicting long-term recovery outcomes.

Already rising from these new recovery support institutions is the concept of *community recovery*—the idea that broader social systems beyond the individual have been significantly wounded by severe and prolonged AOD dependence and related problems that may require a process of consciousness-raising and sustained healing. Coyhis (Coyhis & White, 2002) has referred to this community recovery process as a "healing forest" within which the individual, family, community, and culture are healed simultaneously.

It is incumbent on addiction professionals to become students of and participants within this national and international transformation of the ecology of recovery (2009a). The goal of the new recovery advocacy movement is to create a world in which recovery can flourish. It appears the construction of that world is well under way.

Acknowledgement: The authors would like to thank Pat Taylor of Faces and Voices of Recovery for her assistance in identifying resources identified in Table 2. This article was prepared as a briefing paper for the 2012 Betty Ford Institute/UCLA Annual Conference on Recovery.

References

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. doi:10.1016/j.jsat.2007.06.001

Borkman, T. J., Kaskutas, L. A., Room, J., Bryan, K., & Barrows, D. (1998). An historical review and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, *15*(1), 7-17. doi:10.1016/S0740-5472(97)00244-4

Botzet, A. M., Winters, K., & Fahnhorst, T. (2007). An exploratory assessment of a college substance abuse recovery program: Augsburg College's StepUP Program. *Journal of Groups in Addiction and Recovery, 2*(2-4), 257-270. doi:10.1080/15560350802081173

Chartier, K. G., & Caetano, R. (2011). Trends in alcohol services utilization from 1991-1992 to 2001-2002: Ethnic group differences in the U.S. population. *Alcoholism: Clinical & Experimental Research*, *35*(8), 1485-1497. doi:10.1111/j.1530-0277.2011.01485.x

Cleveland, H. H., Harris, K. S., Baker, A. K., Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment, 33*(1), 13-23. doi:10.1016/j.jsat.2006.11.005

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical concept. *Substance Use and Misuse, 43*(12-13), 1971-1986. doi:10.1080/10826080802289762

Cohen, P., & Cohen, J. (1984). The clinician's illusion. *Archives of General Psychiatry, 41*, 1178-1182.

Coyhis, D., & White, W. (2002). Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor, 3*(5), 16-20.

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Cunningham, J. (1999). Untreated remission from drug use: The predominant pathway. *Addictive Behaviors*, *24*(2), 267-270. doi:10.1016/S0306-4603(98)00045-8

d'Arlach, L., Olson, B. D., Jason, L. A., & Ferrari, J. R. (2006). Children, women, and substance abuse: A look at recovery in a communal setting. *Journal of Prevention & Intervention in the Community*, *31*(1-2), 121-131. doi:10.1300/J005v31n01_11

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. doi:10.1111/j.1530-0277.1996.tb01685.x
Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.
Dennis, M. L., & Scott, C.K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence, 121*, 10-17. doi:10.1016/j.drugalcdep.2011.07.026
Dodd, M. H. (1997). Social model of recovery: Origin, early features, changes and future. *Journal of Psychoactive Drugs*, *29*(2), 133-139.
El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine, 6*, 1-9. doi:10.1097/ADM.0b013e31823ae540
Ferrari, J. R., Curtin-Davis, M., Dvorchak, P., & Jason, L. A. (1997). Recovering from alcoholism in communal-living settings: Exploring the characteristics of African American men and women. *Journal of Substance Abuse*, *9*, 77-87. doi:10.1016/S0899-3289(97)90007-9
Gibson, R. L. (1991, April). *School-based recovery support: The time is now*. Presented at the annual convention of the American Association of Counseling and Development, Reno, Nevada, April 21-24.
Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). The effect of Assertive Continuing Care on continuing care linkage, adherence, and abstinence following residential treatment for adolescents with substance use disorders. *Addiction*, *102*, 81-93. doi:10.1111/j.1360-0443.2006.01648.x
Harris, K. S., Baker, A. K., Kimball, T. G., & Shumway, S. T. (2007). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 220-237. doi:10.1080/15560350802080951
Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,…Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, *26*(3), 151-158. doi:10.1016/S0740-5472(03)00212-5
Janzen, R. (2001). *The rise and fall of Synanon: A California Utopia*. Baltimore: Johns Hopkins University Press.
Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*, *32*, 803-818. doi:10.1016/j.addbeh.2006.06.014
Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health, 96*, 1727-1729. doi:10.2105/AJPH.2005.070839
Jason, L. A., Olson, B. D., Ferrari, J. R., Majer, J. M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, *102*, 1114-1121. doi:10.1111/j.1360-0443.2007.01846.x
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.facesandvoicesofrecovery.org
Kaplan, L. (2003). *Substance abuse treatment workforce environmental scan*. Rockville, MD: Center for Substance Abuse Treatment.
Kaplan, L., Nugent, C., Baker, M., & Clark, H. W. (2010). Introduction: The Recovery Community Services Program. *Alcoholism Treatment Quarterly*, *28*, 244-255. doi:10.1080/07347324.2010.488522
Kaskutas L. A., Subbaraman, M. S., Witbrodt, J., & Zemore, S. E. (2009). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ): A group format 12-step facilitation approach. *Journal of Substance Abuse Treatment, 37*(3), 228-239. doi:10.1016/j.jsat.2009.01.004

Kelly, J. F., Dow, S. J., & Westerhoff, C. (2011). Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms. *Journal of Drug Issues*, *40*, 805-818. doi:10.1177/002204261004000403

Kelly, J. F., & Westerhoff, C. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*, *21*, 202-207. doi:10.1016/j.drugpo.2009.10.010

Kelly, J. F., & White, W. L. (2011). *Addiction recovery management: Theory, research and practice*. New York: Springer.

Kelly J. F., & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue, & J. R. Cunningham (eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

Laudet, A. B. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and resarch. *Substance Use & Misuse*, *43*, 2001-2020. doi:10.1080/10826080802293459

Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106*(3), 657-669. doi:10.1111/j.1360-0443.2010.03194.x

Magura, S. (2003). The role of work in substance dependency treatment: A preliminary overview. *Substance Use and Misuse*, *38*(11-13), 1865-1876.

Majer, J. M., Jason, L. A., North, C. S., Ferrari, J. R., Porter, N. S., Olson, B.,…Molloy, P. (2008). A longitudinal analysis of psychiatric severity upon outcomes among substance abusers residing in self-help settings. *American Journal of Community Psychology, 42*(1-2), 145-153. doi:10.1007/s10464-008-9190-z

McKay, J. R. (2009). *Treating substance use disorders with adaptive continuing care*. Washington, D.C.: American Psychological Association.

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment*, *25*, 117-121. doi:10.1016/S0740-5472(03)00156-9

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.

Moberg, D. P., & Finch, A. J. (2007). Recovery high schools: A descriptive study of school programs and students. *Journal of Groups in Addiction and Recovery*, *2*(2-4), 128-161. doi:10.1080/15560350802081314

Molloy, P., & White, W. L. (2009). Oxford Houses: Support for recovery without relapse. *Counselor, 11*(2), 28-33.

Moos. R. H., & Finney, J. W. (2011). Commentary on Lopez-Quintero et al. (2011): Remission and relapse—the Yin-Yang of addictive disorders. *Addiction*, *106*, 670-671. doi:10.1111/j.1360-0443.2010.00003284.x

Oksanen, A. (2012). To Hell and back: Excessive drug use, addiction, and the process of recovery in mainstream rock autobiographies. *Substance Use & Misuse*, *47*, 143-154. doi:10.3109/10826084.2012.637441

Oxford House, Inc. annual report (2011). Sliver Springs, MD: Oxford House, Inc.

Polcin, D. L., Korcha, R., Bond, J., & Galloway, G. (2010). Eighteen month outcomes for clients receiving combined outpatient treatment and sober living houses. *Journal of Substance Use*, *15*(5), 352-366. doi:10.3109/14659890903531279

Roizen, R., Cahalan, D., & Shanks, P. (1978). "Spontaneous remission" among untreated problem drinkers. In D. B. Kandel (Ed.), *Longitudinal research on drug use, empirical findings and the methodological issues* (pp. 197-221). New York: John Wiley & Sons.

Room, J. (1998). Work and identity in substance abuse recovery. *Journal of Substance Abuse Treatment*, *15*(1), 65-74. doi:10.1016/S0740-5472(97)00250-X

Roth, J., & Finch, A. (2010). *Approaches to substance abuse and addiction in education communities: a guide to practices that support recovery in adolescents and young*. Philadelphia: Taylor & Francis Group.

Roth, J. D. (2010). Crossing international boundaries in recovery from addiction. *Journal of Groups in Addiction & Recovery, 5*(3-4), 179-182. doi:10.1080/1556035X.2010.523335

Rubington, E. (1967). The halfway house for the alcoholic. *Mental Hygiene, 51*, 552-560.

Schutte, K. K., Moos, R. H., & Brennan, P. L. (2006). Predictors of untreated remission from late-life drinking problems. *Journal of Studies on Alcohol*, *67*, 354-362.

Shaw, S., & Borkman, T. (1990/1991). *Social model alcohol recovery: An environmental approach*. Burbank, CA: Bridge Focus, Inc.

Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health*, *86*(7), 966-972.

Spicer, J. (1993). *The Minnesota Model: The evolution of the interdisciplinary approach to addiction recovery.* Center City, Minnesota: Hazelden Educational Materials.

Storbjork, J., & Room, R. (2008). The two worlds of alcohol problems: Who is in treatment and who is not? *Addiction Research and Theory*, *16*(1), 67-84. doi:10.1080/16066350701578136

Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2010. Data on substance abuse treatment facilities* (DASIS Series S-59, HHS Publication No. (SMA) 11-4665). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Swanson, L., & McBean, T. (2011). *Bridges to grace: Innovative approaches to recovery ministry*. Grand Rapids, MI: Zendervan.

White, W., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. L. (2000). Listening to Lazarus: The voices of America's first "Reformed Drunkards". *Contemporary Drug Problems, 26*, 533-542.

White, W. L. (2001a). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly, 19*(1), 1-21. doi:10.1300/J020v19n02_01

White, W. L. (2001b). Recovery university: The campus as a recovering community. *Student Assistance Journal, 13*(2), 24-26.

White, W. L. (2002). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly*, *19*(4), 1-32. doi:10.1300/J020v19n04_01

White, W. L. (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.

White, W. L. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703. doi:10.1111/j.1360-0443.2007.01808.x

White, W. L. (2008a). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. L. (2008b). *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. L. (2009a). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158. doi:10.1016/j.jsat.2008.10.006

White, W. L. (2009b). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L. (2011). *A chronology of recovery mutual aid groups in the United States*. Retrieved March 3, 2012 from www.williamwhitepapers.com.

White, W. L., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

White, W. L., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor, 7*(2), 54-58.

Williams, C., with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York: Harper San Francisco.



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. (2012). Recovery Carriers. Posted at **www.williamwhitepapers.com**

Recovery Carriers

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

In a series of recent essays, I discussed the proposition "Recovery is contagious." The central points in these essays are that:

- Addiction recovery is often caught before it is chosen—meaning that one can get swept up in recovery in a process as unplanned and as irrational as how one got caught up in addiction.
- Long-term addiction recovery involves conscious (voluntary) choices, but that may not be how recovery begins.
- Catching recovery means that one can initiate recovery even while actively resisting it, e.g., consciously trying to hustle your way through treatment or peer mutual aid to get people off your back only to "catch recovery" in spite of yourself.
- Catching recovery involves exposure to people in recovery with whom one can identify and who serve as catalysts of personal change.
- What appear to be sudden, dramatic recovery conversion experiences are often set in motion by exposure to an agent of recovery: Jerry McAuley's (founder of the urban mission movement in the U.S.) religious conversion in prison was preceded by contact with another person in recovery (the prize fighter Orville "Awful" Gardner); AA co-founder Bill W.'s conversion-like experience in Towns Hospital was preceded by a visit from his newly sobered friend Ebby T.; Malcolm X's conversion in a prison cell to the Nation of Islam was preceded by communications from his brother and sister who were already members of the Nation.)
- Recovery initiation is as much an interpersonal process as an intrapersonal process; increasing family and community recovery capital can have as much influence on recovery initiation as increasing intrapersonal recovery capital.
- A central strategy for building community recovery capital is through efforts that increase the density of *recovery carriers*.
- The density of recovery carriers exerts a profound influence on community recovery prevalence (the total number of people in recovery

within a defined catchment area) and community recovery incidence (the number of people initiating recovery in a defined catchment area within a set period of time—usually the past 12 months).
- Communities can take action to strategically increase the density of recovery carriers within the whole community or in particular neighborhoods.

Since the posting and publication of these essays, I have received many questions about this role of recovery carrier. The primary purpose of this essay is to describe this recovery carrier role in greater detail.

Defining the Recovery Carrier

Recovery carriers are people, usually in recovery, who make recovery infectious to those around them by their openness about their recovery experiences, their quality of life and character, and the compassion for and service to people still suffering from alcohol and other drug problems.

The recovery carrier is in many ways the opposing face of the addiction carrier—the person who defends his or her own drug use by spreading excessive patterns of use to all those he or she encounters. The pathology of addiction is often spread from one infected person to another; some individuals are particularly contagious. Highly infectious addiction carriers can be found in most drug use settings, always willing to induct newcomers, always pushing "just one more," always pushing the furthest boundaries of risk. In fact, some addiction carriers have, after their own recovery initiation, become quite effective recovery carriers as a form of amends for the past harm they caused to others by recruiting and inducting them into the culture of addiction.

So who and what exactly is this *recovery carrier*? The role is not unique to a particular pathway of recovery. Recovery carriers can be found in religious, spiritual, and secular recovery mutual aid societies and those in recovery without affiliation with any such group. The role is not defined by age—the recovery carrier is not synonymous with elder status in communities of recovery—nor is it unique to a particular gender. It is not a role requiring superior intelligence or academic achievement. I have seen people with advanced degrees inspired into recovery by those with meager education. Being a recovery carrier does not require occupational success or social status. In the recovery world, value comes from much different sources. The personalities and interpersonal styles of recovery carriers can vary markedly. Some are gifted with great energy and charismatic speech, others with serene wisdom and quiet dignity, still others with a self-deprecating, healing humor. What they share in common is three observable traits: 1) people are almost magnetically drawn to them—even those needing but not actively seeking recovery, 2) they exude a kinetic energy that elicits confidence and readiness for action in those around them, and 3) people who spend time with them and stay connected to them seem to recover and achieve a high quality of life in recovery.

The Big Book of Alcoholics Anonymous says to its readers, "Our stories disclose in a general way what we used to be like, what happened, and what we are like now. <u>If you have decided you want what we have</u> and are willing to go to any length to get it--then you are ready to take certain steps." (underline added by author, Alcoholics Anonymous, 1939, p. 70.) Recovery carriers are people who have more of those qualities that others want and a clearer understanding of the steps required to acquire such attributes.

The source and exact nature of this magnetic energy is unclear; it is not something one can acquire in school or a professional training program. It is not so much what one knows or does—knowledge or actions that could be imparted by education or training—as much as who one is and how one relates to others. In listening to people describing how they "caught recovery," there are consistent themes in how recovery carriers are described and

what made contact with them so catalytic. Comments like the following are typical.

> "He used to freak me out by saying things like, 'Are you tired of living behind that mask?' or he would call me when I was back using and ask, 'How's that high life working for you?' He messed with my head, but he hung in with me, and I kept going back to him until I got my head together."
>
> "I could not write off ___(name) as I had so many other would-be helpers. It wasn't even like he was helping. Others wanted to drop their pearls of wisdom and run. He was comfortable just being with me."
>
> "I knew if I wanted to stay out there in the life, I needed to stay away from her cause she was the real deal."
>
> "He kept telling me with this big smile on his face that I was full of shit but that he still loved me. He was telling the truth on both counts. I was and he did."
>
> "She kept calling to see how I was and to say she had been thinking about me at a time no one was thinking about me--even while she was going through cancer treatment. How does someone do that?"
>
> "Everyone had threatened me or given me advice; he gave his story and gave me hope. He didn't have any advice, only experience."
>
> "Every time I tried to praise her for all she had done, she would just smile and tell me she was just another drunk trying to stay sober and do what was right. I started thinking maybe I could be like her someday."

The hard-to-define essence of the recovery carrier may well be his or her ability to live and speak what AA-Cofounder Bill W. referred to as "the language of heart."

I suspect, at least for the near future, that such traits can be identified, nurtured into maturity, and channeled into innumerable service channels but not artificially created where they do not naturally exist. I don't think just anyone can be a recovery carrier with or without recovery experience. (The history of recovery in America is filled with people who performed this role who were not in personal recovery.) I don't think this is something you can decide to be. It is rather something that emerges within some people out of the very process of recovery or from experiencing what Ernie Kurtz (1996) described as their "own dark night of the soul."

I think the traits so critical to this role must be fed to be sustainable. And yet I think it is quite possible that conditions could be set within a community and within communities of recovery (the image of community petri dishes with a rich growing medium comes to mind) within which recovery carriers can rise. I suspect a major breakthrough of the future will lie not in the further isolation of addicted individuals within institutional environments but in seeding their natural community environments with recovery carriers. How might this be achieved? Experiments are underway in places like the City of Philadelphia to answer that question.

References

Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism. (1955). New York: Alcoholics Anonymous World Services, Inc.

Kurtz, E. (1996). Spirituality and recovery: The historical journey. *The Blue Book, 47*, 5-29.



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. (2012). Recovery orientation in methadone maintenance: A definitional statement. Posted at **www.williamwhitepapers.com**

Recovery Orientation in Methadone Maintenance: A Definitional Statement

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

In 2010, Lisa Mojer-Torres and I co-authored a monograph entitled *Recovery-oriented Methadone Maintenance*. Since its publication, the application of the concept of recovery to the methadone maintenance treatment (MMT) context has been both warmly embraced and at times hotly debated. Interestingly, proposals for recovery-oriented methadone maintenance (ROMM) have been criticized from both poles in the often vitriolic debates about MMT. Criticisms stem from differences in definitions of recovery and the resulting criteria for recovery status and fears that the ROMM concept will result in unanticipated harm to opioid treatment programs (OTPs), harm reduction programs, recovery mutual aid groups, and to those served by these organizations. Could a newly proposed concept produce such harm? Of course. There is a long tradition of harm in the name of help within the history of addiction treatment, and any concept, no matter how well-intended, may be hijacked and corrupted to support purposes for which it was not intended. Those possibilities underscore the importance of conceptual clarity and the rigorous testing of new ideas and service approaches.

Although the ROMM philosophy and related changes in service practices were detailed in the 2010 monograph with extensive scientific citations, there appears to be the need for a short simple declaration of what ROMM is and is not. Such a declaration would ideally help ground continued discussion. This brief paper offers such a statement. The ROMM concept will continue to evolve through continued dialogue and evolving scientific findings on its central elements, but the statement below will provide a starting point for discussion reflecting the views of the authors who first proposed it.

ROMM Defined

Recovery-oriented methadone maintenance (ROMM) is an approach to the treatment of opioid addiction that combines methadone pharmacotherapy and a sustained menu of professional and peer-based recovery support services to assist patients and families in initiating and maintaining long-term addiction recovery—

recovery defined here as remission of primary and secondary substance use disorders, enhancement of personal/family health and functioning, and positive community reintegration (White & Torres, 2010). Recovery supports within the ROMM framework span the stages of pre-recovery identification and engagement, recovery initiation and stabilization, the transition to recovery maintenance (during medication maintenance and, for those who choose to taper, throughout and following the tapering process), and the enhancement of quality of personal/family life in long-term recovery (White, 2009, 2012).

ROMM is not….

Any time a revived or new conceptual framework is introduced that challenges existing service practices, there are innumerable efforts to reject or colonize the concept to minimize its threat and to protect prevailing personal, professional, and institutional interests. There are also quite legitimate attempts to challenge new or revised frameworks that may be ineffective or even harmful. It is hoped that ROMM will be critically evaluated both conceptually and at a service practice level. Achieving that will require maintaining the clarity of precisely what is being proposed via the ROMM concept. All kinds of fears have been expressed to the author about the overt and hidden agendas within the ROMM proposal. So, to begin with,

ROMM is <u>NOT</u> an effort to:

1) Raise the motivational bar of admission to MMT.
2) Limit methadone dosages or the duration of MMT.
3) Define methadone cessation as a criterion for recovery status.
4) Pressure MMT patients to end medication maintenance.
5) Deny or discourage MMT patient access to other treatment modalities or harm reduction information or services.
6) Mandate counseling or peer support services for stabilized patients who do not need or want such services.
7) Extrude patients who do not adopt the goal of full recovery.
8) Deny stabilized patients access to interim or office-based treatment.
9) Impose remission/recovery criteria on MMT patients different than the remission/recovery criteria applied to all persons with substance use disorders (White, 2012).

Put simply, the goal of ROMM is not to eliminate long-term MMT or other historically defined harm reduction programs. The focus is instead on elevating the quality of such services by ensuring that full recovery (with or without medication support) is a visible and supported option at all stages of service engagement.

ROMM Philosophy Does…

The proposal for ROMM was an attempt by the authors to 1) personally and professionally assert the scientific, clinical, and cultural legitimacy of MMT as a treatment for opioid addiction, 2) retrieve, celebrate, and extend the best recovery-linked practices within the history of MMT, 3) reframe MMT within emerging models of sustained recovery management and within larger recovery-oriented systems of care, and 4) outline service practices that could elevate support for long-term recovery of MMT patients and their families.

ROMM asserts that MMT patients who achieve remission from all substance use disorders and who demonstrate improvement in global health and community re-integration meet the criteria of recovery status regardless of whether they decide to sustain long-term methadone maintenance or taper and sustain their recoveries without

medication support. (In short, recovery is defined by functional status rather than medication status.) ROMM further argues that, to fulfill this recovery vision, recovery-oriented service practices must be retrieved that were lost during the regulation and mass dissemination of MMT, and that new recovery-oriented service practices must be added to existing and future opioid treatment programs (OTPs).

ROMM Service Practices Do…

In preparing the ROMM monograph, the authors reviewed countless scientific studies on opioid addiction treatment and recovery and talked with innumerable MMT patients and their family members, MMT patient advocates, and leading experts on the treatment of opioid addiction. What emerged was a sharpened vision of the kinds of service practices that could be implemented, evaluated, and refined to enhance long-term recovery outcomes from opioid addiction.

ROMM as a Model of Sustained Recovery Management Advocates:

Recovery Representation: Inclusion of current and former recovering patients and their family members within all governance and advisory bodies and within paid and volunteer treatment and recovery support teams; infusion of people in recovery within the treatment milieu—hope via living proof of potential for long-term recovery.

Attraction Strategies: Community education, assertive "street" and institutional outreach, guided service linkage, elimination of personal/environmental obstacles to service initiation/retention—all aimed at shortening addiction careers and extending recovery careers.

Accelerated Access: Streamlined intake; assertive management of waiting lists for service entry; access to interim medication maintenance.

Optimum Dose Stabilization: Individualized optimal dosing with rapid response to needed dose adjustments over time; no restrictions on duration of medication maintenance; no use of medication dose as reward or punishment for compliance or non-compliance; clinical re-evaluation in response to continued drug use; rapid identification of sub-therapeutic dosing; access to office-based dosing for highly stabilized patients in long-term recovery.

Global Assessment Protocol: Phased, multi-dimensional clinical assessment processes that are comprehensive, strengths-based, continual; assessment of family, social network, and community recovery capital; strong emphasis on patient/family self-assessment.

Recovery Planning: Phased transition from professionally directed treatment plans to patient-directed recovery plans; mobilization of community resources to assist implementation of personal recovery plans.

Retention Strategies: Emphasis on therapeutic alliance with each patient/family; assertive responses to continued drug use; prompts following missed appointments; assertive follow-up to re-engage all patients who drop out of treatment.

Recovery-focused Partnership with Patients: Shift from expert to partnership/recovery consultant relational model; focus on relationships based on mutual respect; focus on care and support rather than control.

Multidisciplinary Recovery Support Team: Expansion of service team to include greater involvement of primary care physicians, mental health professionals, and peer recovery coaches; greater use of ASAM-certified physicians

in patient/family education; greater use of current former patients in volunteer recovery support roles.

Culture of Recovery: Develop a strong recovery culture within the OTP milieu, e.g., Patient Council; visible recovery role models; recovery-focused activities/rituals, language, symbols, values, art, music.

Recovery-focused Patient/Family Education: Structured patient/family education as a visible component of treatment induction process.

Expanded Professional Service Menu: Broadened array of ancillary services with personal focus on how particular services can be uniquely combined and sequenced with medication to enhance stabilization and long-term recovery outcomes.

Primary/Psychiatric Health Care Integration: Delivery of primary health care and psychiatric services via co-location of services or partnership agreements.

Peer-based Recovery Support Services: Peer recovery support services made available to all patients, e.g., recovery coaching/mentoring, stage-appropriate recovery education, introduction to advocacy and community service opportunities, recovery-supportive social activities, support for lifestyle reconstruction.

Linkage to Communities of Recovery: On-site recovery support meetings; orientation and assertive linkage to mediation-friendly recovery mutual aid meetings and other recovery support institutions, e.g., recovery homes, recovery schools, recovery ministries, recovery community centers, recovery cafes, recovery-focused art/music/theatre/sports projects.

Enhanced Supports for Patients Choosing to Taper: Education on risks/benefits of tapering;
Self-assessment exercises on readiness and timing of tapering; increased access to counseling and peer-recovery support resources; safety-net plan for post-tapering adjustment period; option of advanced directives with family.

Post-treatment Recovery Check-ups: Post-treatment recovery check-ups defined as part of MMT and included in informed consent process at admission; face-to-face, telephone, or internet follow-up of all discharged patients—regardless of discharge status; saturated contact in first 90 days following treatment; at least annual recovery check-ups for five years following discharge from treatment; responsibility for contact resides with staff not the patient.

Patient Opportunities for Recovery Advocacy/Support and Community Service: Invitation to patients to participate in recovery advocacy and community service events; training opportunities in recovery storytelling, recovery coaching, peer leadership; creating volunteer service corps for involvement in community service projects; ensuring inclusion of patients in medication-assisted treatment within local recovery community organization activities.

Recovery-focused Evaluation Measures: Treatment effectiveness measures that include recovery-focused system benchmarks and personal recovery outcomes—including measures of remission (and their social cost influences, e.g., crime, health care utilization), changes in global health, social functioning, and quality of life; regular (at least annual) public disclosure of key recovery benchmark measures.

Recovery-focused Professional & Public Education: Sponsorship or participation in educational events that

challenge the stigma attached to MMT by accurately portraying the role medications can play in recovery initiation and long-term recovery maintenance and providing MMT patient/family advocates opportunities to offer "living proof" of medication-assisted recovery via their own stories.

Those wishing further details on these proposals are referred to the references below for more in-depth presentations.

References

Bamber, S., & White, W. L. (2011). Dialogue I: Recovery-oriented Methadone Maintenance. Retrieved from www.williamwhitepapers.com

McLellan, A. T., & White, W. L. (2012). Opioid maintenance and recovery-oriented systems of care: It is time to integrate. Invited commentary on *Recovery-oriented drug treatment: An interim report by Professor John Strang*, *Chair of the Expert Group*. London, England: The National Treatment Agency. *DrugLink*, July/August, pp12-12.

White, W., Parrino, M., & Ginter, W. (2011). *A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions*. Briefing paper for SAMHSA's A Dialogue on Psychopharmacology in Behavioral Healthcare meeting, October 11-12, 2011.

White, W. L. (2009). *Long-term strategies to reduce the stigma attached to addiction, treatment and recovery within the City of Philadelphia (with particular reference to medication-assisted treatment/recovery)*. Philadelphia: Department of Behavioral Health and Mental Retardation Services.

White, W. L. (2012). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases, 31*(3), 199-206.

White, W. L., & Mojer- Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

All of the above references are posted for free download at www.williamwhitepapers.com

DBHIDS
DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Great Lakes ATTC
Unifying science, education and services to transform lives.

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Recovery/Remission from Substance Use Disorders

An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011

William L. White, MA

Philadelphia Department of Behavioral Health and Intellectual disAbility Services

Great Lakes Addiction Technology Transfer Center

Recovery/Remission from Substance Use Disorders:
An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011

Published by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and the Great Lakes Addiction Technology Transfer Center

Great Lakes Addiction Technology Transfer Center
Jane Addams College of Social Work
University of Illinois at Chicago
1640 West Roosevelt Road, Suite 511 (M/C 779)
Chicago, Illinois 60608-1316

Philadelphia Department of Behavioral Health and Intellectual disAbility Services
1101 Market Street
Philadelphia, PA 19107

March, 2012

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by William L. White and jointly published by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and the the Great Lakes Addiction Technology Transfer Center (GLATTC) under contract number 5 UD1 TI013593-0, with SAMHSA Center for Substance Abuse Treatment (CSAT). Donna M. Doolin, LSCSW, served as the ATTC Project Officer/Public Health Advisor.

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or CSAT. No official support from or endorsement by any of the agencies for these opinions or for particular resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Great Lakes ATTC. For more information on obtaining copies of this publication, call (312) 996-0966.

Produced under a grant funded by the Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Center for Substance Abuse Treatment, 5600 Fishers Lane
Rockwall II, Suite 618, Rockville, Maryland 20857, 301.443.5052
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the agency.

Grant No. 5 UD1 TI013593-0

CSAT
Center for Substance Abuse Treatment
SAMHSA

Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011

Table of Contents

Executive Summary 1

Conclusions and Recommendations 3

Acknowledgments 5

About the Author 5

Introduction 7

The Challenges of Recovery Measurement 8

A Problem of Population Diversity 12

Methodology 16

Community Studies 18

Clinical Studies 33

Clinical Studies (Adult Recovery Rates) 34

Clinical Studies (Adolescent Recovery Rates) 45

Measuring Recovery Prevalence in Philadelphia 48

Discussion 49

Conclusions and Recommendations 55

References 61

Appendices

Appendix A: Recovery Prevalence Studies Among Community Populations 101

Appendix B: Recovery/Remission Rates in Adult Clinical Studies 115

Appendix C: Recovery/Remission Rates in Adolescent Clinical Studies 153

Tables

Table 1: Cessation Patterns among Youth and Young Adults in 2009: Lifetime versus Past-Year Use Rates 18
Table 2: Extrapolated Remission Estimate From Substance Use Disorders for U.S. Adults Based on ECA Study 21
Table 3: Substance Use Disorder Remission/Recovery Estimate based on the National Comorbidity Survey 22
Table 4: Alcohol Use Disorder Recovery Estimate based on National Health Interview 23
Table 5: Estimated Population in Remission from Alcohol Use Disorders 24
Table 6: Estimated Population in Remission from Drug Use Disorders 24
Table 7: Extrapolations of NESARC Data for Projections of National AUD Remission Estimates 25
Table 8: Summary of Remission Rates and Recovery Prevalence Estimates across Studies, 1991-2010 27
Table 9: Studies Chosen for Analysis by Period of Publication 34
Table 10: Remission Probabilities by Drug Choice and Duration of Use 45

Figures

Figure 1: Community Studies, Remission/Recovery Rates 31
Figure 2: Community Studies, Remission/Recovery Rates Published Since 2000 32
Figure 3: Community Studies Remission and Abstinence Rates 33
Figure 4: Recovery/Remission Rate at Last Follow-up, 1868-1959 35
Figure 5: Recovery/Remission Rate at Last Follow-up in the 1960s 36
Figure 6: Recovery/Remission Rate at Last Follow-up in the 1970s 37
Figure 7: Recovery/Remission Rate at Last Follow-up in the 1980s 38
Figure 8: Recovery/Remission Rate at Last Follow-up in the 1990s 39
Figure 9: Recovery/Remission Rate at Last Follow-up, 2000-2004 40
Figure 10: Recovery/Remission Rate at Last Follow-up, 2005-2011 41
Figure 11: Reported Remission Rates by Era 42
Figure 12: Recovery/Remission Rate at Last Follow-up and Abstinence Rates, 1970s-2000s 43
Figure 13: Reported Recovery Outcomes in the Treatment of Adolescent Substance Use Disorders 46

Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011

William L. White, MA

Executive Summary

The emergence of recovery as an organizing paradigm for addiction treatment and the larger arena of behavioral health care underscores the need to measure both early recovery initiation and stabilization and the prevalence of long-term recovery maintenance. Such measurement is critical in evaluating addiction treatment as a system of care and monitoring broader dimensions of community health.

Efforts to measure recovery are challenged by the lack of professional and cultural consensus on the definition and measurement of key constructs (recovery, remission, abstinence, and subclinical/asymptomatic/controlled/moderate use) and by conflicting rates of recovery—rates reported across clinically and culturally diverse populations in studies marked by widely varying methodologies, follow-up periods, and follow-up rates. Of particular import is the wide divergence between portrayals of the natural course of alcohol and other drug (AOD) problems in community populations and portrayals of such problems in clinical populations following specialized addiction treatment. These divergent portrayals constitute the ultimate "apples and oranges" of the AOD problems arena.

The question of recovery stability and prevalence is more than an academic one. The constant media onslaught of celebrities heading back to "rehab" after their latest falls from grace has produced a public unsure of exactly what "recovery" means and whether it is really attainable for all, or for only a few "morally enlightened" exceptions to the rule. The failure of a celebrity to achieve stable recovery garners great cultural attention, while the masses of those in long-term recovery pass invisibly through our culture each day. Recovery surrounds us in our neighborhoods, our businesses, our schools, and our houses of worship, but we do not see it. We see instead the highly visible fruits of the problem. The pessimism flowing from such selective attention feeds misunderstanding and fuels stigma and its far-reaching consequences.

This paper reviews 415 scientific studies of recovery outcomes (79 community studies, 276 adult clinical studies, and 60 adolescent clinical studies) conducted with clinically and culturally diverse populations in multiple countries over the past century. This review provides preliminary answers to five of the most important questions about recovery from alcohol and other drug problems.

1. *How many persons are in recovery from substance use disorders in the United States?*

This question was answered by extrapolating national estimates from the major governmental surveys of the course of alcohol and other drug use and related problems (including the Epidemiologic Catchment Area Study; the National Comorbidity Survey and its replication, the National Health Interview; the National Longitudinal Alcohol Epidemiologic Survey; and the National Epidemiologic Survey on Alcohol and Related Conditions) and from a 2010 recovery survey conducted by the Public Health Management Corporation in Philadelphia, PA and six surrounding counties. Based on this analysis, the percentage of adults in the general population OF the United States in remission from substance use disorders ranges from 5.3% to 15.3%. These rates produce a conservative estimate of the number of adults in remission from significant alcohol or drug problems in the United States at more than 25 million people, with a potential range of 25 to 40 million (not including those in remission from nicotine dependence alone).

2. *What percentage of those who develop AOD problems eventually achieve remission/ recovery?*

Of adults surveyed in the general population who once met lifetime criteria for substance use disorders, an average of 49.9% (53.9% in studies conducted since 2000) no longer meet those criteria. In community studies reporting both remission rates and abstinence rates for substance use disorders, an average of 43.5% of people who have ever had these disorders achieved remission, but only 17.9% did so through a strategy of complete abstinence. One footnote to this high prevalence of non-abstinent remissions in community populations: Alcohol and other drug problems in the community, even problems that meet diagnostic criteria for substance use disorders, are generally less severe, less complex, and less prolonged than those problems found among people entering addiction treatment in the United States.

3. *What is the rate of remission/recovery for persons whose problems are severe enough to warrant professional treatment?*

In an analysis of 276 addiction treatment follow-up studies of adult clinical samples, the average remission/recovery rate across all studies was 47.6% (50.3% in studies published since 2000). Within studies with sample sizes of 300 or more and studies with follow-up periods of five or more years—two factors used as proxy for greater methodological sophistication—average remission/recovery rates were 46.4% and 46.3%, respectively. In the 50 adult clinical studies reporting both remission and abstinence rates, the average remission rate was 52.1%, and the average abstinence rate was 30.3%. Based on available information, this 21.8% difference appears to reflect the proportion of persons in post-treatment follow-up studies who are using alcohol and/or other drugs asymptomatically or are experiencing only subclinical problems (problems not severe enough to meet diagnostic criteria for substance use disorders).

4. *Does the rate of remission/recovery for adolescents following specialized addiction treatment differ from that of adults who have completed such specialized treatment?*

Yes. This analysis compares 276 adult addiction treatment outcome studies conducted between 1868 and 2011 with 60 adolescent addiction treatment outcome studies conducted between 1979 and 2011. The average recovery/remission rate following specialty treatment reported in the adolescent studies was 42% (an average of 35% for studies conducted since 2000), compared to an average recovery/remission rate of 47.6% reported in the adult studies (50.3% average for studies conducted since 2000). Interpretation of this finding should be tempered by the greater number of adult studies, the larger sample sizes, and the much longer follow-up periods in the adult studies. While the high percentage of adolescents who report some AOD use in the months following treatment is discouraging, studies of the longer trajectories of AOD use confirm post-treatment increases in abstinence, reductions in use, and gains in global health among treated adolescents. There is cause for optimism regarding adolescents' long-term prospects for recovery from substance use disorders.

5. *How can local communities establish baseline remission/recovery prevalence data?*

To evaluate community-wide strategies by tracking changes in recovery prevalence over time, local communities can integrate recovery prevalence questions into regular community health surveys. A model for potential replication is the integration of recovery prevalence questions into the bi-annual community health survey conducted in the city of Philadelphia and surrounding counties by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and the Public Health Management Corporation. Such baseline data are being used there and could be used in other communities to guide recovery-focused systems-transformation efforts and to evaluate planned interventions in particular geographical areas (e.g., evaluating service needs by zip codes/planning areas and matching treatment/recovery support resources to those areas where levels of problem severity are highest and levels of recovery capital are lowest).

CONCLUSIONS AND RECOMMENDATIONS

Instability within the Course of AOD Problems and Their Resolution: Point-in-time or short-term studies of AOD problems can mask the complex course of these problems by conveying prognoses that are overly optimistic (assumption that short periods of abstinence or remission are naturally sustainable) or overly pessimistic (assumption that persons resuming AOD use following intervention will all revert to symptomatic use and further escalation of problem severity). Periods of abstinence as long as 3 months are prevailing features of addiction careers and should not be interpreted as sustainable recovery or as evidence that professional help or peer support is not indicated. Successful recovery initiation is distinguishable from a respite within a prolonged addiction career only within a longer time perspective. Both addiction and recovery are best viewed as fluid rather than fixed states, but buried within this fluidity is a natural momentum toward remission and recovery. Even the most

chronic, intractable patterns of addiction contain opportunities for full recovery, and buried within even the most seemingly solid recoveries lie vulnerabilities for reactivation of addiction. This fluidity underscores the need for sustained and assertive recovery management.

Windows of Opportunity for Early Re-intervention: Of those who resume AOD use following treatment, most do so in the first days and weeks. This finding underscores the need for and value of assertive approaches to post-treatment monitoring, support, and early re-intervention for both adults and adolescents.

Role of Community In Recovery: The effects of brief professional interventions on long-term recovery outcomes are more ephemeral than enduring family and social support within one's natural environment. Recovery prevalence is influenced by personal and family factors and by broader historical, cultural, political, and economic influences on the resources available to those who have developed severe AOD problems. Recovery prevalence is shaped as much by community recovery capital as by personal recovery capital.

Solution Perspective versus Problem Perspective: Scientific studies of the long-term resolution of alcohol and other drug problems have constituted an afterthought in the alcohol/drug problems research arena. Substantial benefits might accrue from studies of the prevalence, pathways, stages, and styles of long-term recovery, but not until recently have these been the subject of focused attention. Much of the data available about recovery in this analysis have been extracted from the study of other issues, e.g., studies of the duration of treatment effects, relapse rates, or mortality rates. It is time for focused attention on the lived solutions to AOD problems at personal, family, organizational, community, and cultural levels.

Definition and Measurement: Challenges in defining and measuring recovery from significant alcohol and other drug problems can be overcome to generate national, regional, state, and local recovery prevalence data for purposes of planning, resource allocation, and program- and system-wide performance evaluation. The establishment of such a recovery-focused database should be a high priority at national, state, and local levels.

Recovery Mobilization: There is a significant population of individuals and families in recovery from alcohol and other drug problems in the United States who could be mobilized more widely to support prevention and early intervention programs, serve as volunteers in addiction treatment and recovery support programs, and provide leadership of AOD-related policy advocacy initiatives. Those who were once part of the problem constitute underutilized resources in the search for fresh solutions to America's alcohol and other drug problems.

Recovery Momentum: Studies of clinical populations suffering from severe, prolonged addictions—and the selective media coverage of these populations—create a pessimistic portrayal of the prospects for long-term recovery. According to the data reviewed in this paper, "insanity," prolonged institutionalization, and death are not the normative outcomes of AOD problems. Recovery is not an aberration achieved by a small and morally enlightened minority of addicted people. If there is a natural developmental momentum within the course of AOD problems, it is toward remission and recovery. The central problem is not the difficulty of making recovery possible—that potential clearly exists. It is instead the long duration of time between problem onset and successful recovery stabilization—and the significant harm to individuals, families, and communities in the interim.

Key Questions and Challenges: Recovery from a substance use disorder is more the norm than an anomaly. Given what we know about recovery prevalence and the natural momentum toward recovery, the central research, clinical, and policy questions are:

6. What characteristics of the adolescent, family, treatment milieu, and community environment promote or inhibit the achievement of long-term recovery?
7. What strategies can be used to enhance the resolution of less severe AOD problems (via the elevation of community recovery capital) without the need for professional interventions?
8. How can addiction careers be prevented, quickly aborted, or shortened, and recovery careers extended, to reduce addiction's toll on the individual, family, workplace, community, and society?
9. What professional and peer support interventions can successfully elevate recovery outcomes for those with the greatest problem severity/complexity/chronicity and the least recovery capital?
10. How can recovering people and their families be mobilized to break intergenerational cycles of AOD problem transmission and to serve as a healing force within their local communities and the country as a whole?

These questions lie at the center of the movement to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management for individuals, families, and communities.

Acknowledgements: This paper was sponsored by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, and by the Center for Substance Abuse Treatment via the Great Lakes Addiction Technology Transfer Center. Rod Funk assisted with data analysis and preparation of tables and graphs; Stephanie Merkle and Barbara Weiner assisted with the literature search; and Pamela Woll assisted with the final copyediting.

About the Author: William White is a Senior Research Consultant at Chestnut Health Systems (bwhite@chestnut.org).

Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011

William L. White

We are interested in the maintenance of the behavior, not merely its attainment.

—William Hunt and Wayne General, 1971

INTRODUCTION

During the past decade, the concept of recovery and its related incarnations (e.g., recovery management, recovery-oriented systems of care) have emerged as a new organizing paradigm for addiction treatment[1] and the larger behavioral healthcare arena.[2] While recent progress has brought us closer to a definition of recovery,[3] a quantitative picture of recovery prevalence and recovery rates remains an enigma at professional and public levels. Elaborate data-collection systems have been established to measure the incidence and prevalence of

---

[1] White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*(1), 3-15. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

[2] Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal, 24*(2), 159-168. 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, 34*(2), 109-120. 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. Ralph, R., & Corrigan, P. (Eds.) (2004). *Recovery and mental illness: Consumer visions and research paradigms*. Washington DC: American Psychological Association.

[3] The Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 221-228. McLellan, A. T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment*, *38*, 200-201. SAMHSA (2009). Working definition of recovery. Excerpt from *National Summit on Recovery Conference Report, 2005*. Rockville, MD: Center for Substance Abuse Treatment. United Kingdom Drug Policy Commission. (2008). *A consensus definition of recovery*. Retrieved June 24, 2010 from "http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf" http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf. White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

alcohol- and other drug-related (AOD) problems, but there are few methodologically sophisticated counterparts that regularly report changes in the prevalence of recovery from substance use disorders (SUDs) in the United States.

This paper reviews 415 published community and clinical studies in an attempt to answer five questions:

1. How many persons are in recovery from SUDs in the United States?
2. What percentage of people who develop AOD problems eventually achieve recovery?
3. What is the rate of recovery for persons whose problems are severe enough to warrant professional treatment?
4. Does the rate of recovery for adolescents following specialized addiction treatment differ from that of adults who have completed specialty treatment?
5. How can local communities establish baseline recovery prevalence data that can be used to guide and evaluate recovery-focused systems-transformation efforts?

THE CHALLENGES OF RECOVERY MEASUREMENT

Establishing a recovery rate or a recovery prevalence figure is fraught with innumerable challenges. First is the question: What is recovery, and by what criteria is this status achieved or lost? In their broadest terms, the earlier-cited efforts to define recovery have focused on three broad criteria: 1) reduction of AOD problems to subclinical levels either through abstinence or deceleration of the frequency, intensity, and consequences of AOD use; 2) improvements in global health; and 3) pro-social community reintegration (e.g., reduced injury to community, enhanced citizenship). These criteria reinforce the notion of recovery as more than the removal of alcohol and drugs from an otherwise unchanged life. They further reflect the finding that some individuals who have achieved sustained abstinence following alcohol or other drug dependence remain substantially impaired in terms of their physical health, emotional health, and interpersonal functioning.[4]

Few studies have measured recovery prevalence based on a systematic analysis of all three of these criteria. In fact, many of the studies we will review focus, not on the measurement of recovery itself, but on the study of the general trajectory of AOD problems, the measurement of treatment outcomes, or the study of relapse. With some very notable exceptions, recovery has been an afterthought rather than a subject of focused study.

Terms such as “recovery,” “remission,” “resolution,” and “improved” pervade the studies we will review, but each researcher defines these terms differently, and each person reading such terms may understand their meaning differently. Early studies were unclear about the

[4] 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. Gerard, D., Sanger, G., & Wile, R. (1962) The abstinent alcoholic. *Archives of General Psychiatry, 6*, 83-95. Pattison, E. M., Headley, E. B., Gleser, G. C., & Gottschalk, L. A. (1968). Abstinence and normal drinking: An assessment of change in drinking patterns to alcoholics after treatment. *Quarterly Journal of Studies on Alcohol*, *29*, 610-633.

condition to which the term "recovery" was applied, e.g., AOD users or ill-defined terms such as "problem drinkers," "alcoholics," and "addicts." Some studies using DSM diagnostic criteria included both abuse and dependence populations and did not diagnostically distinguish their reported recovery/remission rates, while other studies focused only on abuse or only on dependence populations. Varying levels of problem type and severity also make it difficult to compare recovery rates across studies. Recovery prevalence figures are further confounded by researchers who use the terms remission or recovery to apply to a reduction in AOD use among persons who may not have met prior diagnostic criteria for substance use disorders.[5]

Terms such as "abstinence," "sobriety," and "clean" (or "clean time" used within American communities of recovery) would appear on the surface to have clear meanings, but this is not the case when such terms appear in research reports. In the latter world, as Dr. George Vaillant suggests, "abstinence is a relative term."[6] Abstinence across these studies may vary in meaning to include:

- continuous abstinence from a primary drug over the follow-up period,
- essential (virtual, partial, near) abstinence—not having consumed more than a specified amount of alcohol or particular drugs during the follow-up period, e.g., averaging less than 1 drink per month;[7]
- minimal abstinence—having achieved a minimum period of recovery status during the follow-up period, e.g., having refrained from consuming heroin for a minimum of 3 months within a 2-year follow-up study;
- point-in-time abstinence—not consuming alcohol or particular drugs at the time of follow-up contact;
- complete abstinence—continuous abstinence from a primary drug, with no use or asymptomatic use of other drugs during the follow-up period; and
- involuntary versus voluntary abstinence—presence or absence of enforced abstinence via hospitalization or incarceration.[8]

Recovery rates and recovery prevalence figures obviously vary depending on the abstinence definition used. It is also noteworthy that persons achieving abstinence following addiction may or may not improve the overall quality of their adjustment/functioning, although

---

[5] Cunningham, J. A. (1999b). Untreated remission from drug use: The predominant pathway. *Addictive Behaviors*, *24*(2), 267-270. Misch, D. A. (2007). "Natural recovery" from alcohol abuse among college students. *Journal of American College Health*, *55*(4), 215-218.

[6] Vaillant, G. E. (1966c). A twelve-year follow-up of New York narcotic addicts: IV. Some characteristics and determinants of abstinence. *American Journal of Psychiatry*, *123*(5), 573-584.

[7] 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. Bergmann, P. E., Smith, M. B., & Hoffman, N. G. (1995). Adolescent treatment: Implications for assessment, practice guidelines, and outcome management. *Pediatric Clinics of North America, 42,* 453-472.

[8] Duvall, H. J., Lock, B. Z., & Brill, L. (1963). Follow-up study of narcotic drug addicts five years after hospitalization. *Public Health Reports, 78*, 185-193.

the number of persons abstinent who continue to function poorly decreases with length of abstinence.[9] Recovery research is progressing beyond a narrow concern with the duration and stability of abstinence or remission toward an increased focus on quality of personal and family life in long-term recovery.[10]

In research the term "recovery" is often used synonymously with the term "remission"—the latter meaning that the person once met DSM-IV diagnostic criteria for a substance use disorder but has not met such criteria in the past year. Information cited in this paper will include total remission rate and, where possible, subcategories of abstinence-based remission and remission through asymptomatic use, e.g., use without problems that reach diagnostic criteria. This latter pattern is reported in the literature under various names, e.g., "controlled drinking," "normal drinking," "social drinking," "asymptomatic use," "subclinical use," "non-abstinent remission," "non-problematic drinking," "non-destructive drinking," "non-hazardous drinking," and "marked improvement"—each with its own definition and the possibility that the definition will vary from study to study.[11]

Recovery/remission prevalence can also sometimes be reported in terms of full remission (no longer meeting diagnostic criteria) or partial remission (meeting diagnostic criteria but at a lower level of problem severity). The latter is also sometimes reported as "improved" or "at-risk use" (use pattern at high risk to re-accelerate into a substance use disorder). Further complicating the issue of recovery measurement are studies that neither report abstinence nor remission rates, but instead report increase or decrease in a particular pattern of use (e.g., change in the percentage of treated clients who use heroin daily) without noting the proportion of the sample that achieved abstinence or no longer met diagnostic criteria for substance use disorders at follow-up.[12] Still other studies report high success rates based on a single area of functioning, without a detailed analysis of global functioning (e.g., Spicer's and Owen's 1985 report that 75% of employed alcoholics returned to normal productivity following treatment).[13]

It should be clear from this brief discussion that the research community has reached no consensus on measurement criteria for recovery. Researchers have answered that question through measurement of such dimensions as continual abstinence; quantity, frequency, and intensity of AOD use; length of time to resumed use following treatment; measures of AOD-related personal/family problems; changes in social costs and threats to public safety related to

---

[9] Pettinati, H. M., Sugarman, A. A., DiDonata, N., & Maurer, H. S. (1982). The natural history of alcoholism over four years after treatment. *Journal of Studies on Alcohol*, *43*, 201-205.

[10] Longabaugh, R., Mattson, M. E., Connors, G. J., & Cooney, N. L. (1994). Quality of life as an outcome variable in alcoholism treatment research. *Journal of Studies on Alcohol Supplement, 12*, 119-129.

[11] Russell, M., Pierce, R. S., Chan, A. W. K., Wieczorek, W. F., Moscato, B. S., & Nochajski, T. H. (2001). Natural recovery in a community sample of alcoholics: Study design and descriptive data. *Substance Use and Misuse*, *36*(11), 1417-1441.

[12] Hubbard, R. L., Cavanaugh, E. R., Craddock, S. G., & Rachal, J. V. (1985). Characteristics, behaviors and outcomes for youth in the TOPS. In A. A. Friedman & G. M. Beschner (Eds.), *Treatment services for adolescent substance abusers* (pp. 49-65). Rockville, MD: National Institute on Drug Abuse.

[13] Spicer, J., & Owen, P. (1985). *Finding the bottom line: The cost impact of employee assistance and chemical dependency treatment programs*. Center City, MN: Hazelden Foundation.

continued use; changes in status on diagnostic criteria for substance use disorders; and broader measures of global health and quality of life.[14]

Reflecting that diversity of measurement, the studies highlighted in this paper use a wide variety of recovery measures, including continual abstinence; abstinence at follow-up; abstinence for a minimum length of time preceding follow-up; quantity, frequency, and intensity of AOD use; the amount of time to resumed use following a helping intervention; measures of AOD-related personal/family problems; changes in AOD use linked to social costs (e.g., arrests, hospitalizations) and threats to public safety related to continued use (e.g., needle sharing, drinking and driving); changes in status on diagnostic criteria for substance use disorders; and broader measures of global health and quality of life.[15] Reported studies also vary widely on length of follow-up, recovery inclusion criteria (meeting criteria continuously over the follow-up period, meeting criteria for a set period of time before follow-up, or meeting criteria the day of follow-up), method of rate calculation (e.g., based on percentage of total original sample or percentage of the follow-up sample), and the degree of verification of recovery status (e.g., self-report only, collateral verification, verification via chemical testing). All of these factors are potential influences on reported rates of recovery.

There is also little agreement on how long a state of improved health must be maintained before recovery status can be assumed to be stable. Reported prevalence rates based on a point-in-time follow-up status or a minimum of three or six months meeting particular recovery criteria differ from rates based on continuous maintenance of that state for five years. The assumption of when recovery is stable and durable—when present recovery status is predictive of lifetime recovery status—varies markedly across the studies we will review.

These opening points represent a way of informing the reader unfamiliar with these studies that conceptual, linguistic, and methodological barriers arise in our attempts to answer questions about recovery rates and recovery prevalence. Reports of the proportion of persons with AOD problems who achieve stable remission/recovery vary considerably based on different population samples (e.g., community versus clinical populations), stringency of problem

---

[14] Babor, T. F., Longabaugh, R., Zweben, A. Fuller, R. K., Sout, R. L., Anton, R. F., & Randall, C. L. (1994). Issues in the definition and measurement of drinking outcomes in alcoholism treatment research. *Journal of Studies on Alcohol*, Supplement 12, 101-111. Longabaugh, R., Mattson, M. E., Connors, G. J., & Cooney, N. L. (1994). Quality of life as an outcome variable in alcoholism treatment research. *Journal of Studies on Alcohol Supplement, 12*, 119-129. Sobell, L. C., Sobell, M. B., Connors, G. J., & Agrawal, S. (2003). Assessing drinking outcomes in alcohol treatment efficacy studies: Selecting a yardstick of success. *Alcoholism: Clinical and Experimental Research, 27,* 1661-1666.

[15] Babor, T. F., Longabaugh, R., Zweben, A. Fuller, R. K., Sout, R. L., Anton, R. F., & Randall, C. L. (1994). Issues in the definition and measurement of drinking outcomes in alcoholism treatment research. *Journal of Studies on Alcohol*, Supplement 12, 101-111. Longabaugh, R., Mattson, M. E., Connors, G. J., & Cooney, N. L. (1994). Quality of life as an outcome variable in alcoholism treatment research. *Journal of Studies on Alcohol Supplement, 12*, 119-129. Sobell, L. C., Sobell, M. B., Connors, G. J., & Agrawal, S. (2003). Assessing drinking outcomes in alcohol treatment efficacy studies: Selecting a yardstick of success. *Alcoholism: Clinical and Experimental Research, 27,* 1661-1666. Sobell, M. B., Sobell, L. C., & Gavin, D. R. (1995). Portraying alcohol treatment outcomes: Different yardsticks of success. *Behavior Therapy*, *26*, 643-669.

definition, degree of problem severity, definitions of remission and recovery, and length of follow-up.[16]

A Problem of Population Diversity

There is considerable disagreement between addiction treatment clinicians and community researchers on the long-term course of alcohol and other drug problems. This is due in great part to the differences in etiology, patterns, and outcomes of AOD problems between treatment populations and larger community populations. As early as 1970, Cahalan and Room, based on their study of problem drinking among American men, cautioned policy makers concerned with such problems against assuming "that the target population is simply the institutional population writ large."[17]

Clinicians who see the most severe, complex, and chronic AOD problems are prone to assume that the problems they see clinically are the tip of an iceberg of similar problems in the larger community that has yet to reach them. They tend to see these problems as progressive, chronically relapsing disorders that can be resolved only through professional treatment and permanent abstinence. Cohen and Cohen[18] christened this worldview of AOD problems as the "clinician's illusion." The problem with the clinician's lens is that only a small percentage (1-3%) of the general population exhibits drinking patterns at levels reported by those entering treatment for alcohol use disorders.[19] This suggests that knowledge of alcohol and drug problems gained in the treatment setting may have only limited applicability to the broader range of such problems in the community.

Epidemiologists who study the trajectory of AOD problems in larger community populations reveal the course of such problems for the 75-90% of affected people who do not seek specialty treatment.[20] These scientists tend to see AOD problems as inherently self-limiting (rather than progressive), resolvable through natural internal and external resources

---

[16] Cunningham, J. A. (1999). Untreated remissions from drug use: The predominant pathway. *Addictive Behaviors*, 24, 267-270.

[17] Cahalan, D., & Room R. (1970). *Problem drinking among American men*. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

[18] Cohen, P., & Cohen J. (1984). The clinician's illusion. *Archives of General Psychiatry*, *41*, 1178-1182.

[19] Room, R. (1968, September). *Amount of drinking and alcoholism*. Paper prepared for the 28th International Congress on Alcohol and Alcoholism, Washington, DC. Polich, J. M., Armor, D. J., & Braiker, H. B. (1980). *The course of alcoholism: Four years after treatment*. New York: Wiley.

[20] Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry*, *64*(7), 830-842. Substance Abuse and Mental Health Services Administration. (2003). *Results from the 2002 National Survey on Drug Use and Health: National findings* (Office of Applied Studies, NHSDA Series H-22, DHHS Publication No. SMA 03–3836). Rockville, MD: Author. Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locker, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorder service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, *50*, 85-94.

(rather than only through professional treatment), and often resolved through a deceleration of the frequency and intensity of use (rather than through complete and enduring abstinence).[21] Moos and Finney[22] christened this worldview of AOD problems the "epidemiologist's illusion."

The widely differing views of addiction and recovery across clinical and community realms is particularly evident in the portrayal of relapse among those seeking recovery. In the clinical world of addiction treatment, relapse is defined as a normal part of the chronic nature of addiction. Addiction treatment professionals can regularly be heard purporting that "relapse is a normal part of the recovery process" (See White, 2010 for discussion).[23] Such communications contribute to the public perception that recovery is a process of trying to stop using alcohol and other drugs rather than a stable, achieved state.[24] And yet community surveys of the recovery community reveal that most people in recovery from alcohol and other drug problems either experienced no AOD use (54%) or only a single brief episode of such use (16%) following recovery initiation.[25] The clinician's pessimism and the epidemiologist's optimism constitute the "two worlds" of AOD problems.[26] Any discussion about measuring and reporting prevalence and styles of long-term recovery must be based on an understanding of the highly variable course of AOD problems and the differences in resolution frequency and resolution methods across these two worlds.

In summary, conclusions drawn from studies of persons in addiction treatment cannot be indiscriminately applied to the wider pool of AOD problems in the community, nor can findings from community studies be indiscriminately applied to the population of treatment seekers. Prolonged repetitions of the abstinence-relapse cycle are not typical in community populations, although they are typical for a subset of the clinical population characterized by high problem severity/complexity and low recovery capital.[27] Most (as many as 75%) people who resolve alcohol-related problems do so without formal treatment.[28] Those who seek help for such

---

[21] Fillmore, K. M. (1974). Drinking and problem drinking in early adulthood and middle age: An exploratory 2-year follow-up study. *Quarterly Journal of Studies on Alcohol*, *35*, 819-840. Kandel, D., & Logan, J. A. (1984). Patterns of drug use from adolescence to young adulthood: I. Periods of risk for initiation, continued use and discontinuation. *American Journal of Public Health, 74*, 660-666. Temple, M. T., & Fillmore, K. M. (1985-1986). The variability of drinking patterns and problems among young men, age 16-31: A longitudinal study. *International Journal of the Addictions, 20*, 1595-1620.

[22] Moos. R. H., & Finney, J. W. (2011). Commentary on Lopez-Quintero et al. (2011). Remission and relapse—the Yin-Yang of addictive disorders. *Addiction*, *106*, 670-671.

[23] White, W. (2010). *Relapse is NOT a part of recovery*. Posted at "http://www.facesandvoicesofrecovery.org" www.facesandvoicesofrecovery.org and "http://www.williamwhitepapers.com" www.williamwhitepapers.com

[24] Office of Communications (2008). *Summary Report CARAVAN Survey for SAMHSA on Addictions and Recovery*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[25] Peter D. Hart Associates (2001). *The Face of Recovery, October 2001*. Washington DC: Faces and Voices of Recovery.

[26] Storbjork, J., & Room, R. (2008). The two worlds of alcohol problems: Who is in treatment and who is not? *Addiction Research and Theory*, *16*(1), 67-84.

[27] Price, R. K., Risk, N. K., & Spitznagel, E. L. (2001). Remission from drug abuse over a 25 year period: Patterns of remission and treatment use. *American Journal of Public Health, 91*, 1107-1113.

[28] 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. Hasin, D.,

problems are the exception. For example, Dawson et al.[29] reported from a national U.S. community sample that 3.1% of persons meeting lifetime criteria for alcohol dependence had attended 12-Step meetings, 5.4% had had treatment only, and 17% had participated in both 12-Step meetings and treatment.

Adults and adolescents entering specialized addiction treatment are distinguished by:

- greater personal vulnerability (e.g., male gender, family history of substance use disorders, child maltreatment, early pubertal maturation, early age of onset of AOD use, personality disorder during early adolescence, less than high school education, substance-using peers, and greater cumulative lifetime adversities),
- greater problem severity (e.g., longer duration of use, dependence, polysubstance use, abuse symptoms co-occurring with substance dependence; opiate dependence),
- greater problem intensity (frequency, quantity, high-risk methods of ingestion, and high-risk contexts),
- greater AOD-related consequences (e.g., greater AOD-related legal problems),
- higher rates of developmental trauma and post-traumatic stress disorder,
- higher co-occurrence of other medical/psychiatric illness,
- more significant personal and environmental obstacles to recovery, and
- lower levels of recovery capital—internal and external resources available to initiate and sustain long-term recovery.[30,31]

Liu, X., & Paykin, A. (2001). DSM-IV alcohol dependence and sustained reduction in drinking: Investigation in a community sample. *Journal of Studies on Alcohol*, *62,* 509-517. Grant, B .F. (1997). Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population sample. *Journal of Studies on Alcohol*, *58*, 365-371. Kessler, R., McGonagle, K, Zhao, S., Nelson, C., Hughes, M., Eshelman, S.,…Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*, 8-19. Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106*(3), 657-669. Schutte, K. K., Moos, R. H., & Brennan, P. L. (2006). Predictors of untreated remission from late-life drinking problems. *Journal of Studies on Alcohol*, *67*, 354-362. Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health*, *86*(7), 966-972.

[29] Dawson, D. A., Grant, B. F., Stinson, F. S., & Chou, P. S. (2006). Estimating the effect of help-seeking on achieving recovery from alcohol dependence. *Addiction*, *101*, 824-834.

[30] Edens, E. L., Glowinski, A. L., Grazier, K. L., & Bucholz, K. K. (2008). The 14-year course of alcoholism in a community sample: Do men and women differ? *Drug and Alcohol Dependence*, *93*, 1-11. Warner, L. A., White, H. R., & Johnson, V. (2007). Alcohol initiation experiences and family history of alcoholism as predictors of problem-drinking trajectories. *Journal of Studies on Alcohol*, *68*, 56-65. King, K. M., & Chassin, L. (2007). A prospective study of the effects of age of initiation of alcohol and drug use in young adult substance dependence. *Journal of Studies on Alcohol and Drugs*, *68*, 256-265. Kuramoto, S.J., Martins, S.S., Ko. J.Y. & Chilcoat, H.D. (2011). Past year treatment status and alcohol abuse symptoms among U.S.adults

The stability of remission without formal treatment varies by sample and length of follow-up, but some studies report high rates of stability. Rumpf and colleagues, in a 24-month follow-

---

with alcohol dependence. *Addictive Behaviors*, 36, 648-653; Grant, B. F. (1996). Toward an alcohol treatment model: A comparison of treated and untreated respondents in a general population sample. *Alcoholism: Clinical and Experimental Research*, *20*, 372-378. Grant, B .F. (1997). Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population sample. *Journal of Studies on Alcohol*, *58*, 365-371. Bischof, G., Rumpf, H., Myer, C., Hapke, U., & John, U. (2004). What triggers remission without formal help from alcohol dependence? Findings from the TACOS-Study. In P. Rosenqvist, J. Blomqvist, A. Koski-Jannes, & L. Ojesjo (eds.), *Addiction and life course. NAD Monograph No. 44* (pp. 85-101). Helsinki Finland: Nordic Council for Alcohol and Drug Research. Kadri, A. M., Bhagylaxmi, A., & Kedia, G. (2003). Study of socio-demographic profile of substance users attending a de-addiction centre in Ahmedabad city. *Indian Journal of Community Medicine*, *28*(2), 74-76. Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. *American Journal of Drug and Alcohol Abuse, 25*(3), 385-406. Grella, C.E., Hser, Y.I.., & Hsieh, S-C (2003). Predictors of drug treatment re-entry following relapse to cocaine use in DATOS. *Journal of Substance Abuse Treatment*, *25*, 145-154. Ross, H. E., Lin, E., & Cunningham, J. (1999). Mental health service use: A comparison of treated and untreated individuals with substance use disorders in Ontario. *Canadian Journal of Psychiatry*, *44*(6), 570-577. Costello, E. J., Sung, M., Worthman, C., & Angold, A. (2007). Pubertal maturation and the development of alcohol use and abuse. *Drug and Alcohol Dependence*, *88*, S50-S59. Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press. Schmidt, L. A., & Weisner, C. M. (2005). Private insurance and the utilization of chemical dependency treatment. *Journal of Substance Abuse Treatment*, *28*, 67-76. Duffy, S. Q., Cowell, A. J., Council, C., & Shi, W. (2006). Formal treatment, self-help, or not treatment for alcohol use disorders? Evidence from the National Household Survey on Drug Abuse. *Journal of Studies on Alcohol*, *67*, 363-372. Leichtling, G., Gabriel, R. M., Lewis, C. K., & Vander Ley, K .J. (2006). Adolescents in treatment: Effects of parental substance abuse on treatment and entry characteristics and outcomes. *Journal of Social Work Practice in the Addictions*, *6*(1/2), 155-174. Norman, S .B., Tate, S. R., Anderson, K. G., & Brown, S. A. (2007). Do trauma and PTSD symptoms influence addiction relapse context? *Drug and Alcohol Dependence*, *90*, 89-96. Schutte, K. K., Moos, R. H., & Brennan, P. L. (2006). Predictors of untreated remission from late-life drinking problems. *Journal of Studies on Alcohol*, *67*, 354-362. Hamburger, M. E., Leeb, R. T. & Swahn, M. H. (2008). Childhood maltreatment and early alcohol use among high-risk adolescents. *Journal of Studies on Alcohol and Drugs*, 69, 292-295. Lloyd, D. A., & Turner, R. J. (2008). Cumulative lifetime adversities and alcohol dependence in adolescence and young adulthood. *Drug and Alcohol Dependence*, *93*, 217-226. Hingson, R. W., Heeren, T., & Edwards, E. M. (2008). Age at drinking onset, alcohol dependence, and their relation to drug use and dependence, driving under the influence of drugs, and motor-vehicle crash involvement because of drugs. *Journal of Studies on Alcohol and Drugs*, *69*, 192-201. Moos, H. B., Chen, C. M., & Yi, H.-Y. (2007). Subtypes of alcohol dependence in a nationally representative sample. *Drug and Alcohol Dependence, 91*, 149-158. Cohen, P., Chen, H., Crawford, T. N., Brook, J. S., & Gordon, J. (2007). Personality disorders in early adolescence and the development of later substance use disorders in the general population. *Drug and Alcohol Dependence*, *88*, S71-S84.

[31] The only major exception to these findings is a study by Carroll and Rounsaville (1992) that found remarkably similar levels of problem severity and complexity in a comparison of cocaine users in the community and those entering treatment. Carroll, K. M., & Rounsaville, B. J. (1992). Contrast of treatment-seeking and untreated cocaine abusers. *Archives of General Psychiatry, 49*, 464-471.

up of a German community sample of people who had remitted from alcohol dependence without professional help, found a 91% remission rate at follow-up.[32]

As we proceed, we will try to distinguish carefully what we know about the resolution of AOD problems across community and clinical populations. Put simply, rates of recovery vary significantly across levels of problem severity, complexity, and duration.[33] Prediction of recovery rates, whether for individuals or for communities, must be based on understanding of this principle. A portion of persons with AOD problems moves in and out of such problem states over relatively short periods[34] and throughout longer periods of their lives.[35] Also blurring these boundaries are scientific studies of "treated" and "untreated" populations, studies whose definition of treatment differ, e.g., differences in whether participation in such activities as brief advice, detoxification, counseling not focused on addiction treatment, or participation in recovery mutual aid societies are included within the rubric of "treatment." In short, those who have participated in AA, NA, or another recovery support group could be included in a community ("untreated") population in one study and a "treated" population in another study. Caution is the watchword as we proceed to summarize what we know about recovery prevalence across these two overlapping worlds.

METHODOLOGY

The starting goal of this analysis was to identify 400+ scientific studies that reported rates of recovery from substance use disorders. By design, those selected represent:

- the more than 150 years over which such studies have been conducted (from the 1860s to the present),
- diverse national contexts (including the U.S., Australia, Canada, Denmark, England, Germany, Holland, Scotland, Sweden, and South Africa),
- diverse cultural contexts (including multiple studies with primarily African American, Native American, and Hispanic samples),

---

[32] Rumpf, H.-J., Bischof, G., Hapke, U., Meyer, C., & John, U. (2006). Stability of remission from alcohol dependence without formal help. *Alcohol and Alcoholism*, *41*(3), 311-314. doi:10.1093/alcalc/agl008

[33] Cunningham, J. A. (1999). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*, 60, 463-466.

[34] Booth, B. M., Fortney, S. M., Forteny, J. C., Curran, G. M., & Kirchner, J. E. (2001). Short-term course of drinking in an untreated sample of at-risk drinkers. *Journal of Studies on Alcohol*, *62*, 580-588.

[35] Ray, M. (1961). The cycle of abstinence and relapse among heroin addicts. *Social Problems, 9*, 132-140. Ray, M. B. (1968). Abstinence cycles and heroin addicts. In E. Rubington & M. Weinberg (Eds.), *Deviance: The interactitionist perspective* (pp. 484-492). London: Macmillan. Scott, C. K., Foss, M. A., & Dennis, M. L. (2005). Pathways in the relapse-treatment-recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, *28*(Supplement 1), S63-S72. Schuckit, M. A., Tipp, J. E., & Bucholz, K. K. (1997). Periods of abstinence following onset of drug dependence in 1,853 men and women. *Journal of Studies on Alcohol*, *58*, 581-589. Watson, C. G., & Pucel, J. (1985). The consistency of posttreatment alcoholics' drinking patterns. *Journal of Consulting and Clinical Psychology*, *53,* 679-683.

- untreated community populations (70+ studies) and treated populations (200+ studies),
- a wide spectrum of primary drug choices,
- all levels of care and a wide diversity of treatment methods, and
- multiple subpopulations (e.g., adolescents, older adults, women, physicians, homeless people, people with co-occurring psychiatric illness).

The goal was to be as inclusive as possible in reporting the recovery outcomes of diverse populations treated in diverse settings through the widest spectrum of methods. The goal was not to identify the best methods of treatment or to report recovery outcomes in the most controlled conditions. Rather, it was to report recovery outcomes across ALL populations, methods, and settings and to report on rates of recovery outcomes with and without professional treatment.

The studies were identified through standard computer literature searches (e.g., PubMed, ETOH, PsychInfo) conducted by the author and research assistants Stephanie Merkle and Barbara Weiner. Also reviewed was the collection of treatment outcome studies housed at the Illinois Addiction Studies Archives. Those studies that reported a measurable prevalence or rate of recovery were organized into three master tables (community studies, adult clinical studies, and adolescent clinical studies—See Appendices A-C). These raw data were then analyzed by research associate Rod Funk to construct graphs and tables illustrating the major findings that will appear below.

The recovery rates presented in the tables are based on varying definitions of remission, recovery, improvement, and success. As noted, they represent different methods of rate calculations, with some recovery rates based on a percentage of the total original samples and others calculated on graduates or survivors at follow-up. Some report rates for multiple subgroups without reporting a rate for all study participants. For these studies, the rate reported in this analysis is the average of the reported means across study subgroups. If a study reported only a recovery rate range (e.g., between 40 and 50%), the rate listed for that study was the average within that range (e.g., 45%). Where remission/recovery rates were reported for multiple points of follow-up, the figure reported here is for the remission/recovery rate at the last point of follow-up.

In discussing the available data, we will use two terms: "recovery prevalence" and "recovery rate." As used here, "recovery prevalence" will indicate the number of people in a given population who have met diagnostic criteria for DSM-IV substance use disorders at some point in their lives but who have not met diagnostic criteria for at least the past year. "Recovery rate" will indicate the percentage of people who have had SUDs at some point in their lives but who do not meet SUD diagnostic criteria at follow-up or for a specified time period—usually reported as an annual or lifetime rate. We will focus in this paper primarily on lifetime recovery rates.

COMMUNITY STUDIES

We will start our discussion of the natural course of AOD problems with studies of the natural course of AOD use in the general population of the United States.

The NSDUH and MTF Studies of AOD Desistance Patterns: There are two major surveys used to track substance use trends in the United States—the National Survey on Drug Use and Health (NSDUH) and the Monitoring the Future (MTF) youth survey. For each year the NSDUH provides estimates on the prevalence of "substance abuse and dependence" in the general population (22.2 million persons in 2008), the number of people in need of AOD-related treatment (23,051,000—slightly larger than the clinical SUD population), and the number of people who received AOD-related treatment (2,287,000 at a specialty facility), but it does not measure recovery prevalence in the general population.[36] In other words, these surveys can reveal patterns of AOD cessation or reduced frequency of use, but not the portions of such changes that occur in persons who previously experienced substance use disorders. These surveys do provide data on selected patterns of drug desistance, which can be obtained by comparing self-reported lifetime use rates with past-year use rates for particular drugs for youth and young adults (See Table 1).

Table 1: Cessation Patterns among Youth and Young Adults in 2009: Lifetime versus Past-Year Use Rates[37]

Substance	Age 12-17 NSDUH 2009	Age 12-17 MTF 2009	Age 18-25 NSDUH	Age 18-25 MTF 2009
Alcohol	38.1 / 30.3	47.9 / 41.6	85.8 / 78.8	85.7 / 82.0
Cigarettes	22.2 / 15.0	26.4 / NA	63.7 / 45.2	NA / 35.0
Marijuana	17.0 / 13.6	24.0 / 19.3	52.2 / 30.6	53.8 / 32.1
Cocaine	1.6 /1.0	3.6 / 2.2	14.8 / 5.3	12.2 / 5.7

In 2008, 48.9% of persons aged 18 or older reported lifetime use of illicit drugs, but only 13.7% of those surveyed reported illicit drug use in the past year.[38] The portion of these desistance patterns for youth, young adults, and older adults resulting from recovery from a

[36] Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD., Figure 7.1; Table G.32.

[37] Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

[38] Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD., Table G.13.

substance use disorder versus a cessation of early drug experimentation is, as we noted, unknown. Surveys outside the United States reveal similar trends. In a Canadian population survey, Cunningham[39] found cessation rates (drug use in lifetime but not in past year) ranging in the 80th percentile for cocaine, LSD, amphetamines, and heroin.

Studies of heavy and binge drinking among college students also confirm that only a small percentage of students maintain harmful drinking as a continuous pattern over time. For example, Weingardt and colleagues[40] studied drinking patterns of college students over time and found that only 18.5% of college students continued to meet binge drinking criteria over a span of four years. Vik and colleagues[41] found that 22% of students with a history of binge drinking in adolescence reduced their drinking during their college years and did so without formal treatment.

There is natural momentum toward reduction/cessation of illicit drug use in the transition from adolescence into adulthood.[42] Decelerated use, cessation of use, and recovery for adolescents are intertwined with maturational transitions into adulthood, e.g., completing high school, leaving home, marriage or cohabitation, full-time employment, paying bills, and having children.[43] Community studies also reveal a second wave of decline in alcohol use and related problems after age 50.[44]

While most desistance studies do not provide a basis for calculating recovery prevalence, they do underscore the natural trend toward a deceleration of AOD use over time in most individuals—a broad trend that we shall soon see also applies to clinical as well as community populations. At the community level those who follow patterns of desistance also blend into the larger pool of abstainers who never used alcohol or drugs, or who once used but no longer use such substances. Over the past 40 years, studies of drinking patterns in the U.S. have generally found about a third of the population reporting that they do not consume

---

[39] Cunningham, J. A. (1999). Untreated remissions from drug use: The predominant pathway. *Addictive Behaviors*, 24, 267-270.

[40] Weingardt, K. R., Baer, J. S., Kivlahan, D. R., Roberts, L. J., Miller, E. T., & Marlatt, G. A. (1998). Episodic heavy drinking among college students: Methodological issues and longitudinal perspectives. *Psychology of Addictive Behaviors*, *12*, 155-167.

[41] Vik, P. W., Celluci, T., & Ivers, H (2003). Natural reduction of binge drinking among college students. *Addictive Behaviors*, *28*, 643-655.

[42] Kandel, D. B., & Raveis, V. H. (1989). Cessation of illicit drug use in young adulthood. *Archives of General Psychiatry*, *46*, 109-116.

[43] D'Amico, E. J., Ramchand, R., & Miles, J. N. V. (2009). Seven years later: Developmental transitions and delinquent behavior for male adolescents who received long-term substance treatment. *Journal of Studies on Alcohol*, *70*, 641-650. Gotham, H. J., Scher, K. J., & Wood, P. K. (1997). Predicting stability and change in frequency of intoxication from the college years to beyond: Individual-difference and role transition variables. *Journal of Abnormal Psychology*, *106*, 619-629. Muthén, B. O., & Muthén, L. K. (2000). The development of heavy drinking and alcohol-related problems from ages 18 to 37 in a US national sample. *Journal of Studies on Alcohol*, *61*, 290-300. Schulenberg, J., O'Malley, P. M., Bachman, J. G., Wadsworth, K. N., & Johnston, L. D. (1996). Getting drunk and growing up: Trajectories of frequent binge drinking during the transition to young adulthood. *Journal of Studies on Alcohol*, *57*, 289-304.

[44] Cahalan, D., & Room, R. (1972). Problem drinking among American men aged 21-59. *American Journal of Public Health*, *62*, 1473-1482.

alcohol—a mixture of those who never drank and former drinkers who once had or did not have a problem with alcohol but today choose not to drink.[45]

Cahalan, Cisin, and Crossley[46] found that five percent of current drinkers reported earlier histories of heavy drinking, but it is unclear what percentages of these heavy drinkers met diagnostic criteria for an alcohol use disorder. It is likely that many of the same factors that contribute to trends toward deceleration or cessation of drug use over time in the general population (e.g., maturation, competing activities and priorities, boredom with AOD use, untoward consequences of AOD use, fear of future consequences of AOD use, family or social pressure, and religious or spiritual experiences) also operate, perhaps in magnified form, among those with substance use disorders.[47]

In summary, while there is an age-related migration toward reduced consumption in the long run, those with the heaviest patterns of AOD use in mid-adolescence (ages 15-16) are most likely to remain among those who consume the most in early adulthood (ages 24-25) and beyond.[48]

Studies of AOD Problems in Community Populations: Community-based studies of the course of AOD problems began in the United States in the 1950s, although the modern era of alcohol epidemiology might well be said to have started with the studies of Clark, Cahalan, and Room[49] in the late 1960s and 1970s. These were among the first studies to reveal the instability in alcohol problem status over time among non-clinical populations.

In reviewing community studies of recovery prevalence, we will rely on reports from the Epidemiologic Catchment Area Study, the National Comorbidity Survey, the National Health Interview, the National Longitudinal Alcohol Epidemiologic Survey, and the National Epidemiologic Survey on Alcohol and Related Conditions; on a review of recovery prevalence rates drawn from 79 published U.S. community surveys on the course of substance-related disorders; and on a 2010 recovery survey conducted by the Public Health Management Corporation in Philadelphia and six surrounding counties.

The Epidemiologic Catchment Area (ECA) Study: Robins, Locke, and Regier[50] summarized data from a study of the prevalence of psychiatric disorders in the United States. They reported 14.3% lifetime prevalence rates for alcohol abuse/dependence and 6.2% lifetime

---

[45] Knupfer, G., & Room, R. (1970). Abstainers in a metropolitan community. *Quarterly Journal of Studies on Alcohol*, *31*, 108-131.

[46] Cahalan, D., Cisin, I. H., & Crossley, H. M. (1969). *American drinking practices: A national study of drinking behavior and attitudes*. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

[47] Cunningham, J. A. (1999a). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*, *60*, 463-466.

[48] Bagnall, D. (1991). Alcohol and drug use in a Scottish cohort: 10 years on. *British Journal of Addiction*, *86*, 895-904. Kandel, D. B., & Raveis, V. H. (1989). Cessation of illicit drug use in young adulthood. *Archives of General Psychiatry*, *46*, 109-116.

[49] Cahalan, D. And Room, R. (1974). *Problem Drinking among American Men.* New Brunswick: Rutgers Center of Alcohol Studies. Clark, W.B. & Cahalan, D. (1976). Changes in problem drinking over a four-year span. *Addictive Behaviors*, 1, 251-259.

[50] Robins, L. N., Locke, B. Z., & Regier, D. (1991). An overview of psychiatric disorders in America. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric disorders in America: The Epidemiologic Catchment Area Study* (pp. 328-366). New York: The Free Press.

prevalence rates for drug abuse/dependence. They further reported that, of those individuals who had experienced substance use disorders in their lives, 54% of those with alcohol use disorders had been in remission for the past year and 59% of those with drug use disorders had been in remission for the past year (pp. 343-344).[51] Table 2 extrapolates these rates to obtain a recovery prevalence estimate based on the current U.S. adult population.

Table 2: Extrapolated Estimates of Remission from Substance Use Disorders for U.S. Adults Based On ECA Study

Population	Number
Current U.S. Population Age 18 and over	232,458,000 (2009 Census)[52]
Estimated Number in U.S. Experiencing Lifetime Alcohol Use Disorder (14.3% rate)	33,241,494
Estimated Number in U.S. Experiencing Lifetime Drug Use Disorder (8.8% rate)	20,456,304
Estimated Number of U.S. Adults in Remission from Alcohol Use Disorders (54% rate)	17,950,407
Estimated Number of U.S. Adults in Remission/recovery from Drug Use Disorders (59% rate)	12,069,219
Total Estimate of U.S. Adult Population in Remission from Substance Use Disorders	30,019,626 (12.9% of population)

The National Comorbidity Survey: Kessler and colleagues[53] conducted a survey of the prevalence of psychiatric and substance use disorders within the U.S. population aged 15-54 and found that 26.6% of those surveyed met criteria for lifetime substance use disorders (SUD) but only 11.3% met such criteria during the past 12 months. That would suggest an SUD remission rate of 57.5% among the U.S. adolescent and adult population. Extrapolated onto current population figures, this would suggest that 61,833,828 of the 232,458,000 adults aged 18 or higher in the U.S. population have met diagnostic criteria for SUDs in their lives, but that

[51] Robins, L. N., Locke, B. Z., & Regier, D. (1991). An overview of psychiatric disorders in America. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric disorders in America: The Epidemiologic Catchment Area Study* (pp. 328-366). New York: The Free Press.

[52] 2009 Estimate of US adults over age 18: 232,458,000. US Census Figure: 308,700,000 million for 2010 http://www.census.gov/prod/cen2010/briefs/c2010br-01.pdf

[53] Kessler, R., McGonagle, K, Zhao, S., Nelson, C., Hughes, M., Eshelman, S.,…Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*, 8-19.

35,554,451 no longer experience AOD problems serious enough to meet SUD diagnostic criteria.

Table 3: Substance Use Disorder Remission/Recovery Estimate based on the National Comorbidity Survey

Population	Number
Current U.S. Population Age 18 and over	232,458,000 (2009 Census)
Estimated Number Within that Population Experiencing Lifetime SUD (26.6% rate)	61,833,828
Estimated Number of U.S. Adults in Remission/recovery from SUDs (57.5% remission rate)	35,554,451 (15.3% of adult population)

In 2005, Kessler and colleagues published a replication of the National Comorbidity Survey. In the replication study, the lifetime prevalence rate for substance use disorders was 14.6%[54] and the rate of substance use disorders for the past 12 months was 3.8%, suggesting that 10.8%[55] of the population once met but no longer meets DSM-IV criteria for substance use disorders. That 10.8% remission rate would lead to a current estimate of 25,105,464 U.S. adults in remission from substance use disorders.

The National Health Interview: In 1988, the National Institute on Alcohol Abuse and Alcoholism sponsored a supplement to the National Health Interview. In this survey, 18.5% of the U.S. adult population self-identified as former drinkers. Of these, 21% met past DSM alcohol dependence criteria, and 42% met past DSM alcohol abuse criteria.[56] If these rates have continued into the present, they would suggest the recovery prevalence figures for alcohol use disorders represented in Table 4.

[54] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R. & Walters, E.E. (2005). Lifetime prevalance and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 593-603.

[55] Kessler, R.C., Chiu, W.T., Demier, O. & Walters, E.E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorobity Survey replication. *Archives of General Psychiatry*, 62, 617-627.

[56] Hasin, D. S., & Grant, B. (1995). AA and other help seeking for alcohol problems: Former drinkers in the U.S. general population. *Journal of Substance Abuse*, *7*, 281-292.

Table 4: Alcohol Use Disorder Recovery Estimate based on National Health Interview

Population	Number
Current U.S. Population Age 18 and over	232,458,000 (2009 Census)
Estimated Number of Former Drinkers in U.S. Population, based on 1988 Survey Rate	43,004,730
Estimated Number of Former Drinkers with Past Alcohol Use Disorders	27,092,979 (11.6% of adult population)

This estimate of 27,092,979 would not include persons in remission from alcohol use disorder via moderated use of their drinking.

National Longitudinal Alcohol Epidemiologic Survey (NLAES):[57] Dawson[58] conducted a survey of prior-to-past-year alcohol abuse or dependence. In this sample she found a total remission rate of 72.2%—22.3% by abstinence and 49.9% by decelerated drinking that no longer met criteria for abuse or dependence. Hasin and colleagues[59] conducted a survey of 876 adults who self-reported consuming 5 or more drinks at least once in the past year. Two thirds of those meeting diagnostic criteria for alcohol abuse no longer met criteria at one-year follow-up, whereas only one third of those meeting diagnostic criteria for alcohol dependence no longer met criteria at follow-up, with 29% of that group reporting full remission. The major conclusion drawn from this study was that "the course of abuse and dependence differ markedly and significantly" (pp. 132-33).[60]

Hasin and colleagues[61] studied the prevalence of DSM-IV alcohol abuse and dependence in a random sample of 43,093 adults. The 12-month prevalence rate was 4.7% for alcohol abuse and 3.8% for alcohol dependence. The lifetime prevalence rate was 17.8% for alcohol abuse and 12.5% for alcohol dependence. Applying these rates to the total adult population of the United States (232,458,000),[62] we get a remission rate (those meeting lifetime

[57] Use of the NLAES to estimate recovery/remission prevalence for substance use disorders was first suggested to the author in a personal communication August 3, 2009 from Dr. Mark Wellenbring when he was serving at NIH/NIAAA. His figures are updated here based on the latest census data.

[58] 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.

[59] Hasin, D. S., Van Rossen, R., McCloud, S., & Endicott, J. (1997). Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. *Journal of Substance Abuse*, *9*, 127-135.

[60] Hasin, D. S., Van Rossen, R., McCloud, S., & Endicott, J. (1997). Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. *Journal of Substance Abuse*, *9*, 127-135.

[61] Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry*, *64*(7), 830-842.

[62] http://www.census.gov/compendia/statab/2011/tables/11s0007.pdf

diagnostic criteria but not past-year criteria) of 72% for alcohol use disorders—73.6% (40,445,666 persons) for alcohol abuse and 69.6% (26,883,662 persons) for alcohol dependence.

Table 5: Estimated Population in Remission from Alcohol Use Disorders

Diagnosis	Met Diagnostic Criteria Past 12 Months	Met Lifetime Diagnostic Criteria	Remission Rate	Estimated Number of Americans in Remission
Any Alcohol Use Disorder	8.5% (19,758,930)	30.3% (70,434,774)	71.9%	50,675,844
Alcohol Abuse	4.7% (10,925,526)	17.8% (41,377,524)	73.6%	30,451,998
Alcohol Dependence	3.8% (8,833,404)	12.5% (29,057,250)	69.6%	20,223,846

Compton and colleagues[63] reported similar data for drug use disorders in the National Epidemiologic Survey on Alcohol and Related Conditions. These figures are presented in Table 6.

Table 6: Estimated Population in Remission from Drug Use Disorders

Diagnosis	Met Diagnostic Criteria Past 12 Months	Met Lifetime Diagnostic Criteria	Remission Rate	Estimated Number of Americans in Remission
	2% (4,649,160)	10.3% (23,943,174)	80%	19,294,014
Drug Abuse	1.4% (3,254,412)	7.7% (17,899,266)	81.8%	14,644,852
Drug Dependence	.6% (1,394,748)	2.6% 6,043,908	76.9%	4,649,160

National Epidemiologic Survey on Alcohol and Related Conditions (NESARC): Dawson and colleagues[64] presented data on the 2001-2002 National Epidemiologic Survey on Alcohol

[63] Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry*, *64*(5), 566-576.

and Related Conditions (NESARC), based on a U.S. general population survey of 43,093 adults that included data on both abstinent and non-abstinent remissions (drinking without symptoms of an alcohol use disorder [AUD]).

Of those who reported prior-to-past-year alcohol dependence, 75% no longer met dependence criteria and 47.7% were in full remission for the past year (18.2% abstainers, 17.7% low-risk drinkers, and 11.8% asymptomatic risk drinkers). Of those in remission, 29.6% reported having been in remission for five years or more.

Dawson and colleagues[65] reported remission rates for alcohol use disorders over a three-year follow-up period in a general population sample. Their results are summarized in Table 7, with remission prevalence projections for the general population based on the rates reported in their study.

Table 7: Extrapolations of NESARC Data for Projections of National AUD Remission Estimates[66]

Remission Categories	% of Population in NESARC Sample	Projected Estimate for U.S. Population based on 2009 Census of 232,458,000 Aged 18 or Older
Non-abstinent Remission from Alcohol Abuse (drinking with no AUD symptoms)	3.7%	8,600,946
Abstinent Remission from Alcohol Abuse	0.3%	697,374
Non-abstinent Remission from Alcohol Dependence (drinking with no AUD symptoms)	1%	2,324,580
Abstinent Remission from Alcohol Dependence	0.3%	697,374

[64] Dawson, D. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction*, *100*(3), 281-292. Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol use disorders. *Journal of Studies of Alcohol and Drugs*, *69*, 866-77.

[65] Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol use disorders. *Journal of Studies of Alcohol and Drugs*, *69*, 866-77.

[66] Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol use disorders. *Journal of Studies of Alcohol and Drugs*, *69*, 866-77.

Remission Categories	% of Population in NESARC Sample	Projected Estimate for U.S. Population based on 2009 Census of 232,458,000 Aged 18 or Older
Estimate of U.S. Adults in Non-abstinent Remission from Alcohol Use Disorders	4.7%	10,925,526
Estimate of U.S. Adults in Abstinent Remission from Alcohol Use Disorders	0.6%	1,394,748
Total Estimate of U.S. Adults in Remission from Alcohol Use Disorders over a span of 3 years	5.3%	12,320,274 (over a span of three years)
Partial Remission[67] from Alcohol Dependence over a span of 3 years	2.2%	5,114,076

The Dawson et al.[68] data produce lower estimates than those of other studies that compare rates of lifetime substance use disorders with rates of past-year substance use disorders, because these figures represent remission status over a three-year period.

[67] "Partial remission" is defined in this study as not meeting dependence diagnostic criteria, but having one or more symptoms of alcohol abuse or dependence.

[68] Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol use disorders. *Journal of Studies of Alcohol and Drugs*, *69*, 866-77.

Table 8: Summary of Remission Rates and Recovery Prevalence Estimates across Studies, 1991-2010

Study	Remission Rate in Total Population	Remission Rate among Those with Lifetime SUD	Estimated Recovery Prevalence in the U.S. Adult Population Based on 2009 Census of 232,458,000 Aged 18 or Older
Robins, Locke, & Regier, 1991[69]	12.9%	54% for alcohol use disorder and 59% for drug use disorders	30,019,626 (17,950,407 for alcohol use disorders; 12,069,219 for drug use disorders)
Kessler et al., 1994[70]	15.3% for all substance use disorders	57.5% for all substance use disorders	35,554,451
Kessler et al., 2005 replication	10.8% for all substance use disorders	74% for all substance use disorders	25,105,464
Hasin & Grant, 1995[71]	11.6% for persons with an alcohol use disorder	NA	27,092,979 (former drinkers with past alcohol problems)
Dawson, 1996[72]	7.7% for alcohol dependence	72.2%	17,899,266 (in remission from alcohol dependence)
Hasin et al., 1997[73]	12.6% for alcohol use disorders	61% for alcohol abuse; 29% for alcohol dependence	29,289,708 (in remission from past alcohol use disorders)

[69] Robins, L. N., Locke, B. Z., & Regier, D. (1991). An overview of psychiatric disorders in America. In L. N. Robins & D. A. Regier (Eds.), *Psychiatric disorders in America: The Epidemiologic Catchment Area Study* (pp. 328-366). New York: The Free Press.

[70] Kessler, R., McGonagle, K, Zhao, S., Nelson, C., Hughes, M., Eshelman, S.,Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-II-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*, 8-19.

[71] Hasin, D. S., & Grant, B. (1995). AA and other help seeking for alcohol problems: Former drinkers in the U.S. general population. *Journal of Substance Abuse*, *7*, 281-292.

[72] 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.

[73] Hasin, D. S., Van Rossen, R., McCloud, S., & Endicott, J. (1997). Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. *Journal of Substance Abuse*, *9*, 127-135.

Study	Remission Rate in Total Population	Remission Rate among Those with Lifetime SUD	Estimated Recovery Prevalence in the U.S. Adult Population Based on 2009 Census of 232,458,000 Aged 18 or Older
Dawson et al., 2005[74]	10.3% for alcohol dependence	47.7% in full remission from alcohol dependence for past year; 29% in remission 5 or more years	23,943,174 (in remission from alcohol dependence)
Compton et al., 2007[75]	8.3% for drug use disorders	80%	19,294,014 (in remission from drug use disorders)
Hasin et al., 2007[76]	19.8% for alcohol use disorders	72%	46,026,684 (in remission from alcohol use disorders only)
Dawson et al., 2008[77]	5.3% alcohol use disorders over 3 years	44% in full remission	12,320,274 (in remission from alcohol use disorders)
Public Health Management Corporation Community Health Data Base, 2010[78]	9.45% (average of 11.4% rate for Philadelphia and 7.5% rate for suburban counties)	NA	21,967,281 (in remission from past alcohol or other drug problems)

[74] Dawson, D. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction*, *100*(3), 281-292.

[75] Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry*, *64*(5), 566-576.

[76] Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry*, *64*(7), 830-842.

[77] Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol use disorders. *Journal of Studies of Alcohol and Drugs*, *69*, 866-77.

[78] Community Health Data Base, Measures of Interest for the DBHIDS, Philadelphia County: Public Health Management Corporation, 2010, Southeast Pennsylvania Household Health Survey.

Table 8 (above) shows four studies[79] from which the number of people in remission from all alcohol use disorders can be projected (with a mean estimate of 25,847,586), two studies[80] from which remission of alcohol dependence can be projected (with a mean average of 20,921,220), two studies[81] with estimates of remission from drug use disorders (average of 15,681,617), and four studies[82] of remission from all substance use disorders (with an average projected remission estimate in the US of 28,149,206). Based on this, we could conservatively estimate that the number of people in remission from significant alcohol or drug problems in the United States is more than 25 million, with an estimated range of 25-40 million.[83] Most rates of recovery/remission for alcohol and drug use disorders (54-80%) reported in these general population studies suggest that these rates are higher than the rate of adult lifetime tobacco smokers who have quit smoking (51%).[84]

There are, of course, limitations to such estimates rooted in the methodologies used in each of these studies. Studies may inflate the number of people in recovery by assuming that one year in which a subject does not meet diagnostic criteria represents a stability point of recovery, when in fact that subject does not reach stability (the point at which the risk of future lifetime relapse drops below 15%) until after 4-5 years of continuous recovery.[85] Several researchers have determined this set-point for stability to be in the range of five years of continuous recovery and have recommended that remission from addiction, like remission from

---

[79] Robins, et al, 1991; Hasin, et al, 1995; Hasin, et al, 1997; Dawson, 2008.

[80] Dawson, et al, 1996; Dawson, et al, 2005.

[81] Robins, et al, 1991; Compton, et al, 2007.

[82] Robins, et al, 1991; Kessler, et al, 1994l Kessler, et al, 2005; and Public Health Management Corporation, 2010.

[83] A larger estimate can be obtained by looking at changes in heavy drinking. About one third of the U.S. adult population does not drink alcohol, 6-9% of whom report having previously been heavy drinkers (consuming more than 120 drinks per month) or having had prior alcohol problems. Based on an adult population of 232,458,000 (2009 Census), that would mean that between 46,026,684 and 68,140,026 of the nation's non-drinkers are former heavy drinkers—an unknown portion of whom met criteria for an alcohol use disorder. Hilton, M. (1986). Abstention in the general population of the U.S.A. *British Journal of Addiction*, *81*, 95-112. Goldman, E., & Najman, J. (1984). Lifetime abstainers, current abstainers and imbibers: A methodological note. *British Journal of Addiction*, *79*, 309-314.

[84] Centers for Disease Control and Prevention. (2009). Cigarette smoking among adults and trends in smoking cessation—United States, 2008. *MMWR Morbidity and Morality Weekly Report*, 58(44), 1227-1232.

[85] De Soto, C.B., O'Donnell, 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,* 322-334.

cancer, be monitored for a minimum of five years following recovery initiation.[86] Extended recovery is associated with longer periods of initial treatment and more sustained involvement in recovery mutual aid groups,[87] but the principle of recovery stability increasing as a function of time in recovery applies to both treatment-assisted and natural recovery.[88] This suggests the inappropriateness of implying stable outcomes in short-term follow-up studies that describe subjects as abstainers or controlled drinkers as if these were fixed and dichotomous states. Prevalence studies that rely on self-report of resolution of past AOD-related problems may over-inflate recovery estimates by including in this population people who resolved AOD problems that did not meet the severity or duration criteria of substance use disorders. Finally, defining recovery as remission meets only one of the three emerging definitional criteria for recovery—abstinence or remission—without reference to progress toward global health and enhanced quality of life.[89]

There are also factors that can contribute to an underestimate of remission rates. For example, the studies reported do not include people in remission from substance use disorders under age 18, and social stigma attached to AOD problems may result in an underreporting of both past problems and current remission status. Studies that report recovery/remission from AOD problems only in terms of the status of abstinence underreport remission rates by excluding cases in which such problems were resolved through a deceleration of the frequency, intensity, and/or high-risk circumstances of AOD use.

One question related to recovery prevalence is that of recovery rates—the percentage of people in the community who develop AOD problems but later achieve stable recovery from these problems. To address this question, 79 studies of the course of alcohol and other drug problems in the community were analyzed to determine an average recovery rate in non-clinical populations. The results are displayed in Figure 1, with a more complete presentation of the data appearing in Appendix A. The average reported remission/recovery rate for these studies was 49.9%. Figure 2 reveals the average rate of remission found in studies published since 2000 (53.9%).

---

[86] Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051. 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. Loosen, P. T., Dew, B. W., & Prange, A. J. (1990). Long-range predictors of outcome in abstinent alcoholic men. *American Journal of Psychiatry*, *147*, 1662-1666.

[87] Moos, R. H., & Moos, B. S. (2007). Treated and untreated alcohol-use disorders: Course and predictors of remission and relapse. *Evaluation Review*, *31*, 564-584.

[88] Sobell, L. C., Sobell, M. B., Agrawal, S., Leo, G. I, Johnson-Young, L. Toneatto, T., & Somco, E. R. (2001, November). *A longitudinal prospective study of recovery and relapse among untreated alcohol abusers*. Paper presented at the 35th annual meeting of the Association for the Advancement of Behavior Therapy, Philadelphia, PA.

[89] The Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228; White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

Figure 1: Community Studies, Remission/Recovery Rates (49.9% average for all studies)

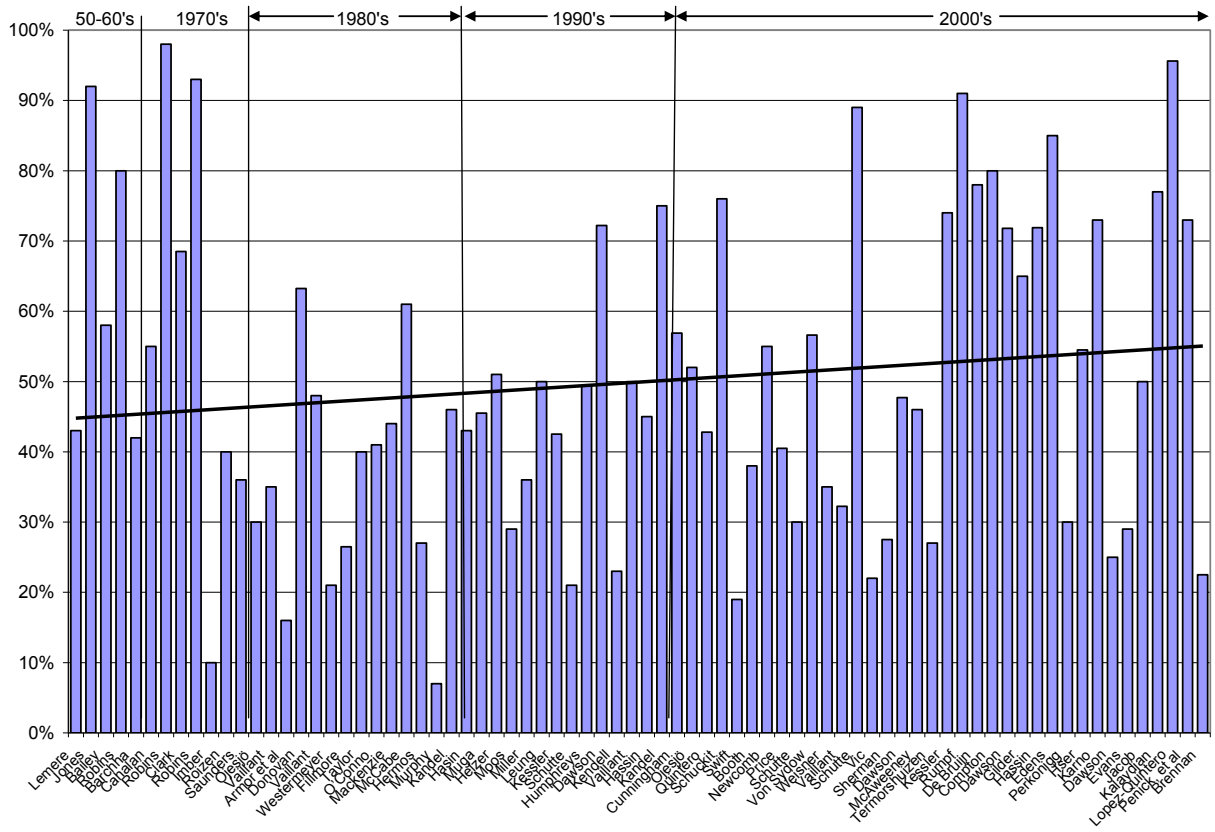
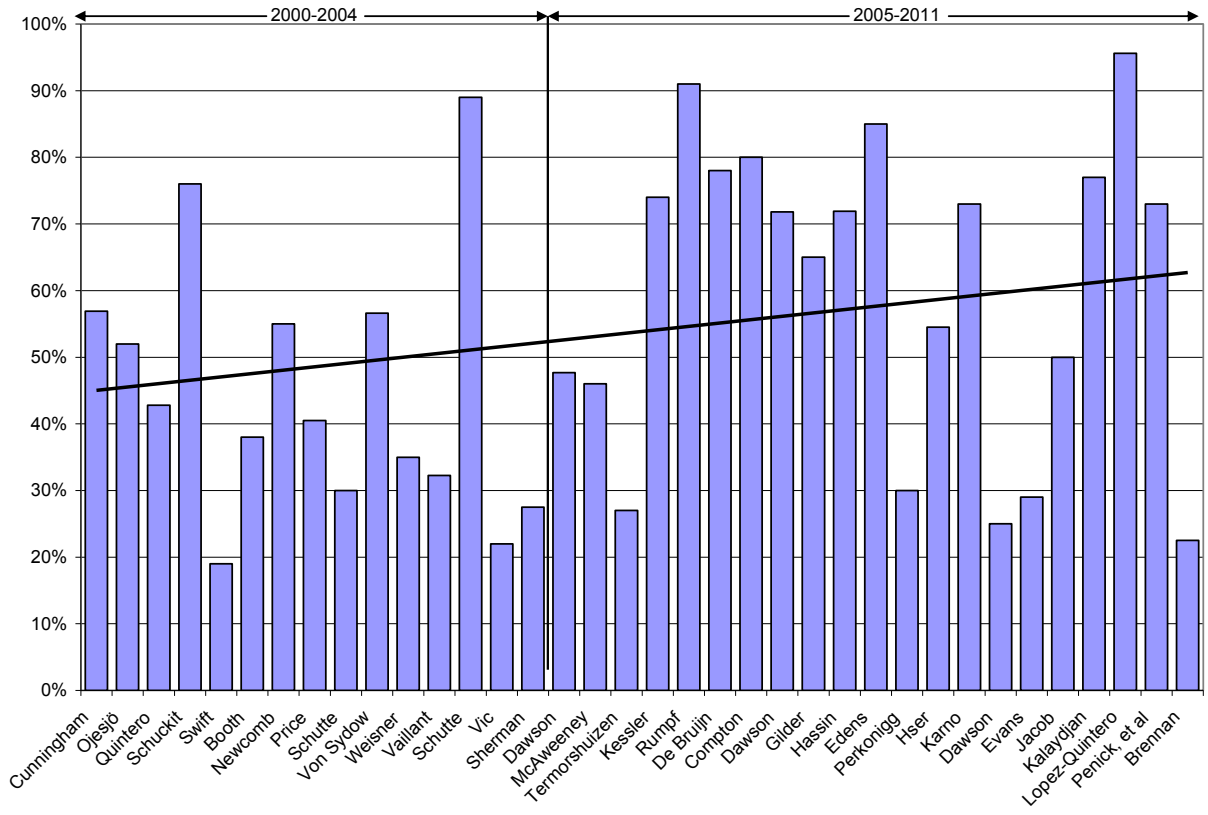
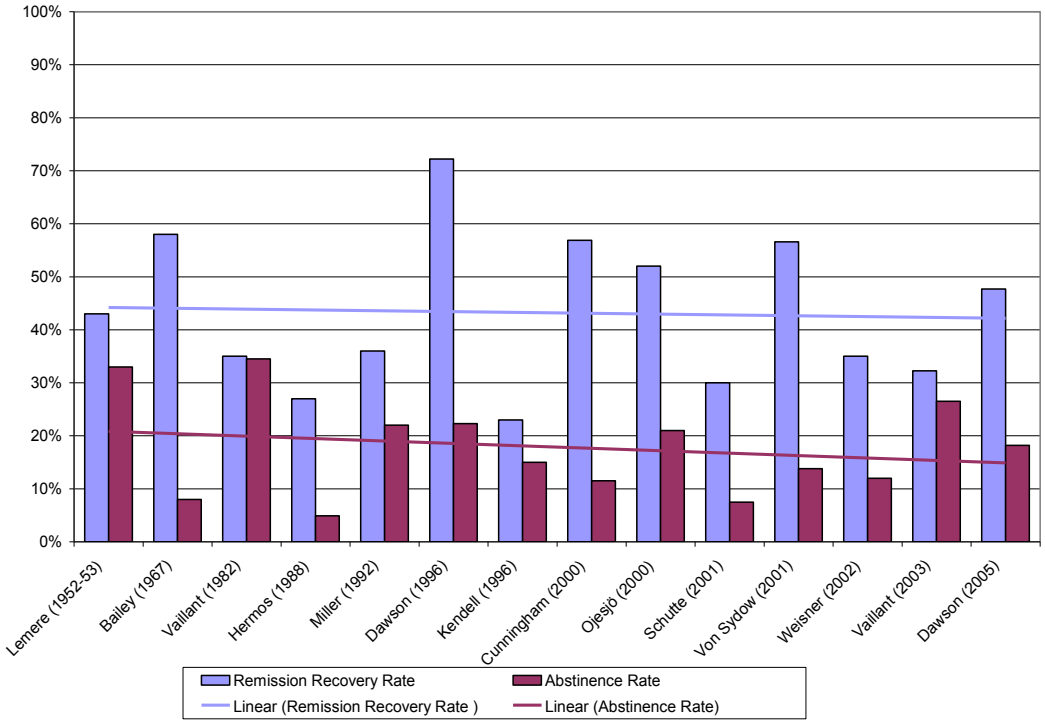


Figure 2: Community Studies, Remission/Recovery Rates Published Since 2000 (53.9% average remission/recovery rate)



These studies, as well as the clinical studies we will review shortly, varied in their definitions of recovery (e.g., some defining recovery as remission—no longer meeting diagnostic criteria for a substance use disorder—and some defining recovery in terms of abstinence). Figure 3 illustrates studies that reported both remission and abstinence outcomes. The average remission rate in these studies was 43.5%, of which 17.9% had achieved remission through complete abstinence.

Figure 3: Community Studies, Remission and Abstinence Rates (Remission rate average = 43.2%, Abstinence rate average = 17.9%)



These data show that almost 60% of people with substance use disorders in the community resolve these problems through a sustained reduction in the frequency and intensity of AOD use rather than through complete abstinence. Why this strategy is more viable for community populations than for clinical populations will be discussed later in this paper.

CLINICAL STUDIES

As noted earlier, there is no clear consensus on how recovery from addiction or from the broader arena of alcohol and other drug problems should be defined or, more specific to the present discussion, how the outcomes of addiction treatment should be measured. There has been considerable debate over the question of whether abstinence should constitute the sole or primary outcome of addiction treatment or the principal measure of recovery from substance use disorders.[90] Measures have included the absence or presence of any AOD use; the

[90] Babor, T. F., Longabaugh, R., Zweben, A. Fuller, R. K., Sout, R. L., Anton, R. F., & Randall, C. L. (1994). Issues in the definition and measurement of drinking outcomes in alcoholism treatment research. *Journal of Studies on Alcohol*, Supplement 12, 101-111.

quantity, frequency, and intensity of use as well as the time to onset of resumed use; the consequences of use; the resumption of the disorder as measured by diagnostic criteria; biological markers of use/injury; functional indicators (e.g., arrest, unemployment, homelessness); and cost indicators.[91] There have also been efforts to create classification systems that reflect these outcomes. For example, Miller and colleagues[92] measured outcomes of problem resolution efforts using four categories: 1) abstinent, 2) asymptomatic use, 3) improved but impaired, and 4) unremitted. Booth and colleagues,[93] in their study of untreated at-risk drinkers, noted three drinking trajectories: 1) current and persistent disorder, 2) transitioning from at-risk drinking to an alcohol use disorder, and 3) transitioning from an alcohol disorder to either less problematic drinking or abstinence.

CLINICAL STUDIES (ADULT RECOVERY RATES)

A total of 276 adult studies reporting recovery/remission rates were identified for this analysis. These studies encompass sample sizes ranging from 19 to more than 8,000, follow-up periods ranging from 3 months to 60 years, and extremely diverse clinical populations. Table 9 displays the number of studies identified within each of several time periods and is followed by figures showing rates of remission shown in these studies.

Table 9: Studies Chosen for Analysis by Period of Publication

Time Period Study was Published	Number of Studies Included in Analysis
1868-1959	44
1960s	31
1970s	42
1980s	31
1990s	41
2000-2004	43
2005-2011	44

[91] Babor, T. F., Longabaugh, R., Zweben, A. Fuller, R. K., Sout, R. L., Anton, R. F., & Randall, C. L. (1994). Issues in the definition and measurement of drinking outcomes in alcoholism treatment research. *Journal of Studies on Alcohol*, Supplement 12, 101-111.

[92] Miller, W. R., Leckman, A. L., Delaney, H. D., & Tinkcom, M. (1992). Long-term follow-up of behavioral self-control training. *Journal of Studies on Alcohol*, *3*, 249-261.

[93] Booth, B. M., Fortney, S. M., Forteny, J. C., Curran, G. M., & Kirchner, J. E. (2001). Short-term course of drinking in an untreated sample of at-risk drinkers. *Journal of Studies on Alcohol*, *62*, 580-588.

Figures 4-8 display average reported remission/recovery rates within each of these periods. The average remission/recovery rate for all 276 adult studies was 47.6%. The studies analyzed here were further subdivided into those with sample sizes greater than 300 and those with a follow-up period of five or more years (as proxies for greater methodological rigor). In the 88 studies with sample sizes greater than 300, there was an average recovery/remission rate of 46.4%. In the 74 studies with follow-up periods of five years or greater, there was an average recovery/remission rate of 46.3%. Across all of the studies reviewed that were published since 2000, there was an average reported remission/recovery rate of 50.3%.

Figure 4: Recovery/Remission Rate at Last Follow-up, Years 1868-1959 (Average recovery rate of 49.8% across 44 studies)

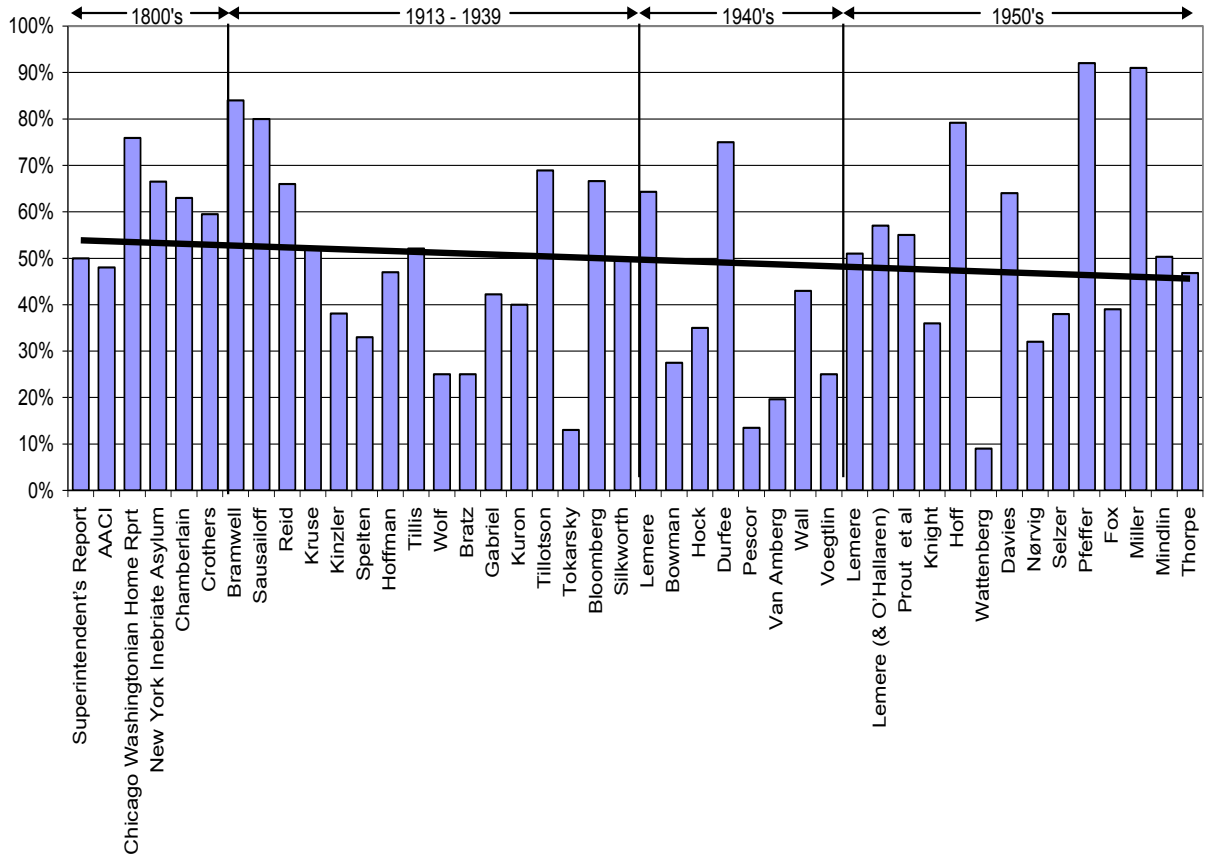


Figure 5: Recovery/Remission Rate at Last Follow-up in the 1960s (Average rate of 40.4% across 31 studies)

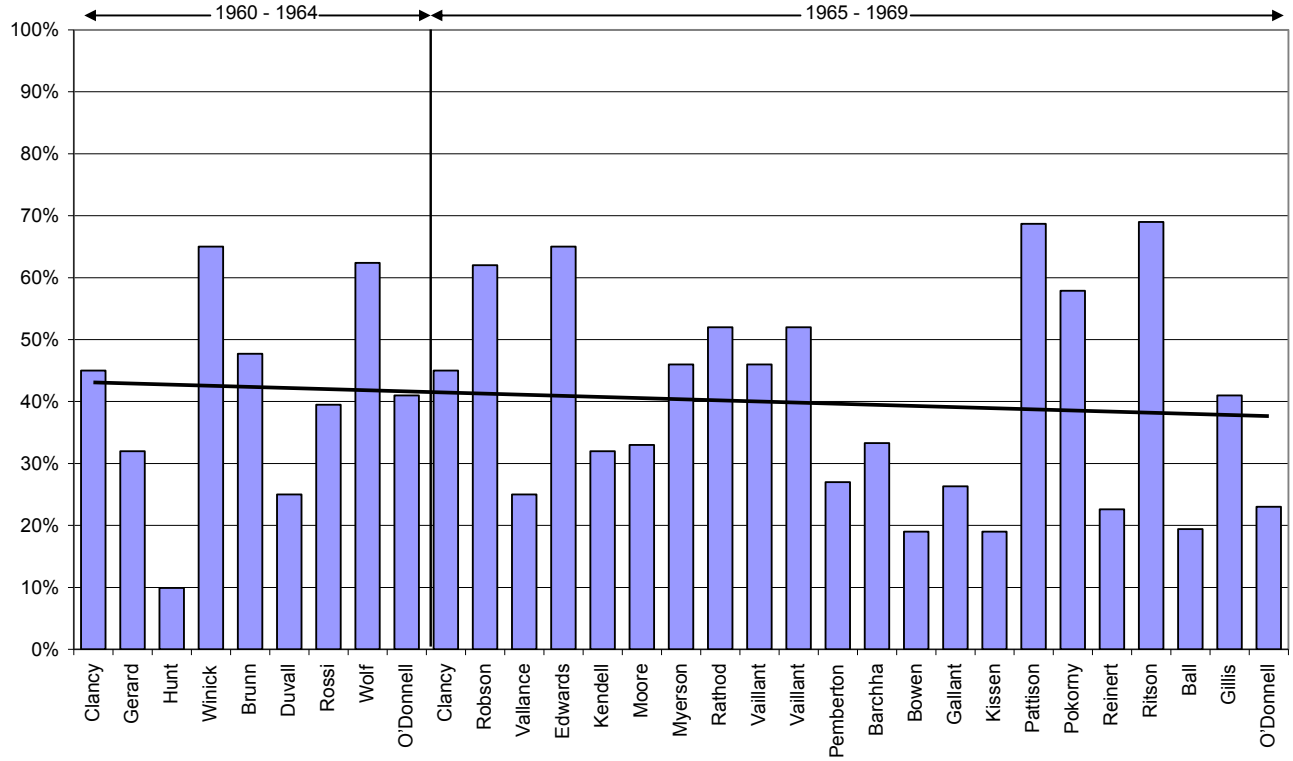


Figure 6: Recovery/Remission Rate at Last Follow-up in the 1970s (Average recovery rate of 43.4% across 42 studies)

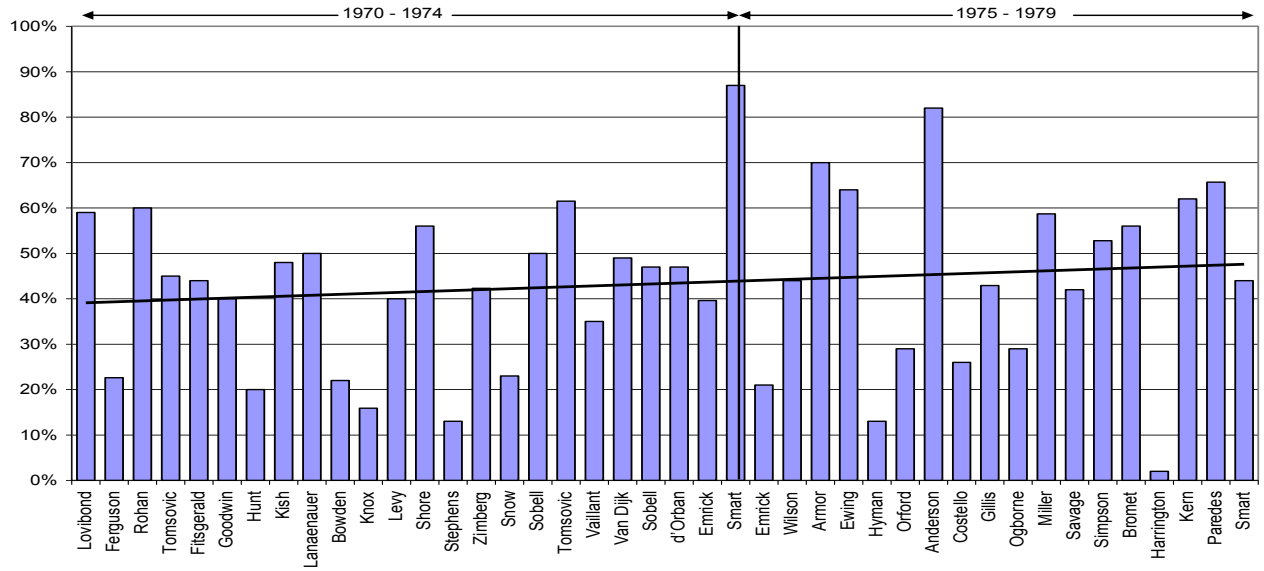


Figure 7: Recovery/Remission Rate at Last Follow-up in the 1980s (Average recovery rate of 47.9% across 31 studies)

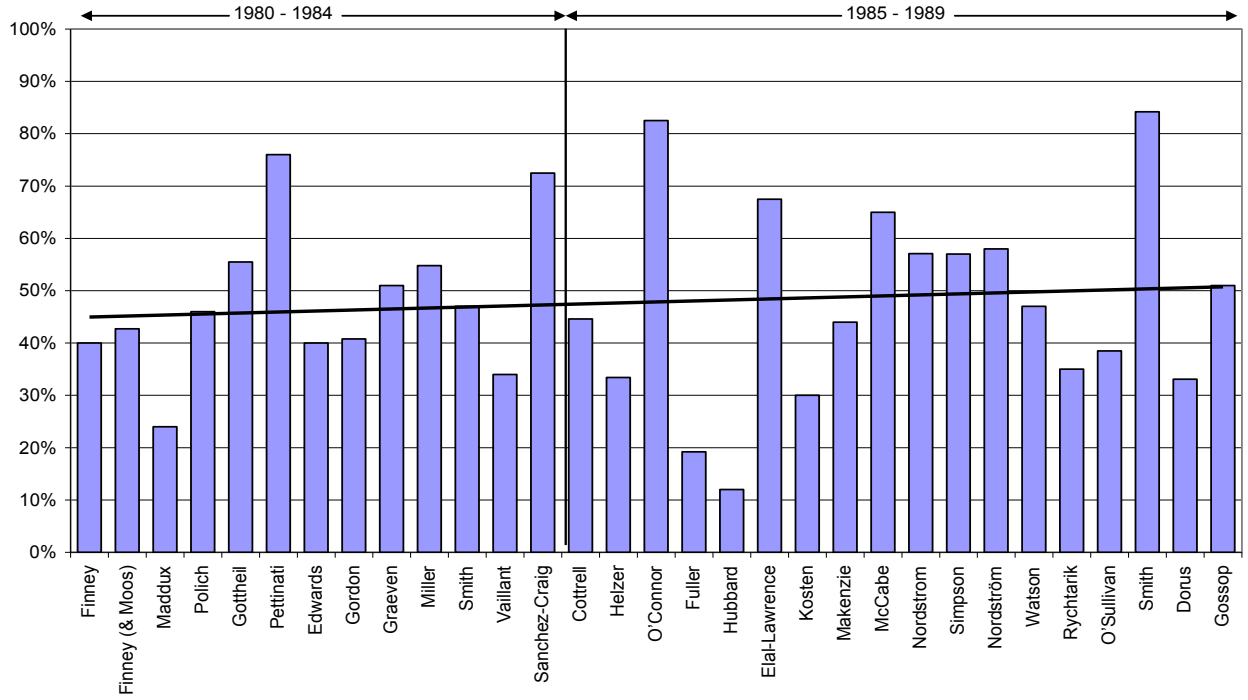


Figure 8: Recovery/Remission Rate at Last Follow-up in the 1990s (Average recovery rate of 48.9% across 41 Studies)

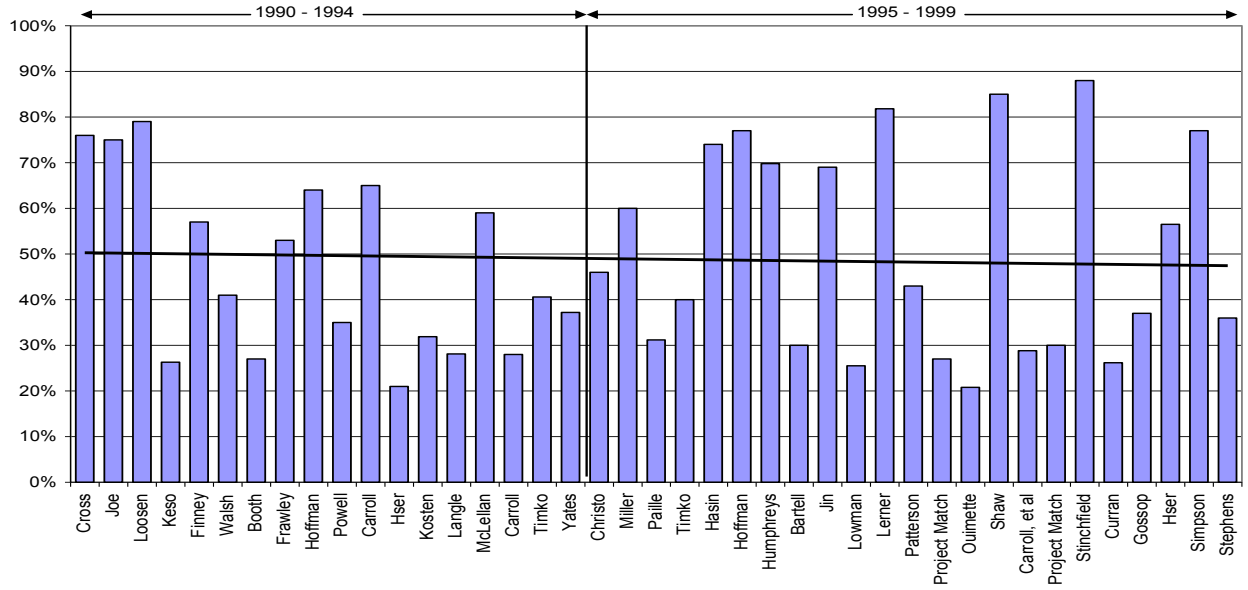


Figure 9: Recovery/Remission Rate at last Follow-up, 2000-2004 (Average recovery rate of 45.9% across 43 Studies)

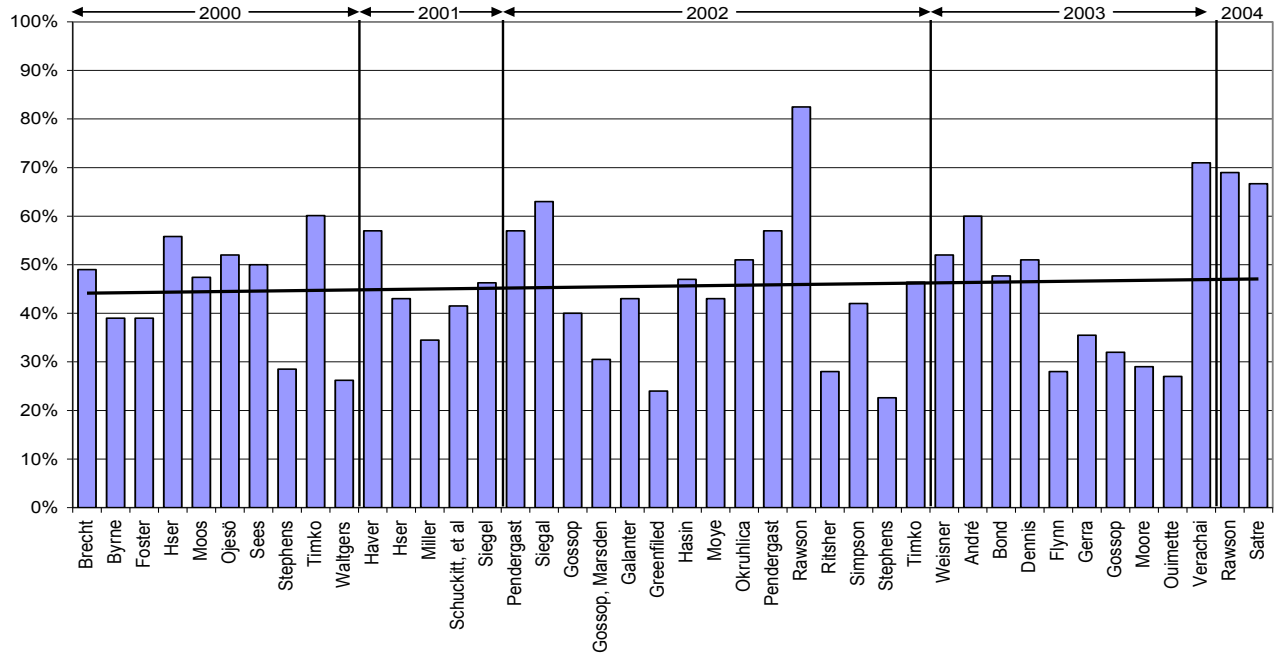


Figure 10: Recovery/Remission Rate at Last Follow-up, 2005-2011 (Average rate of 54.6%)

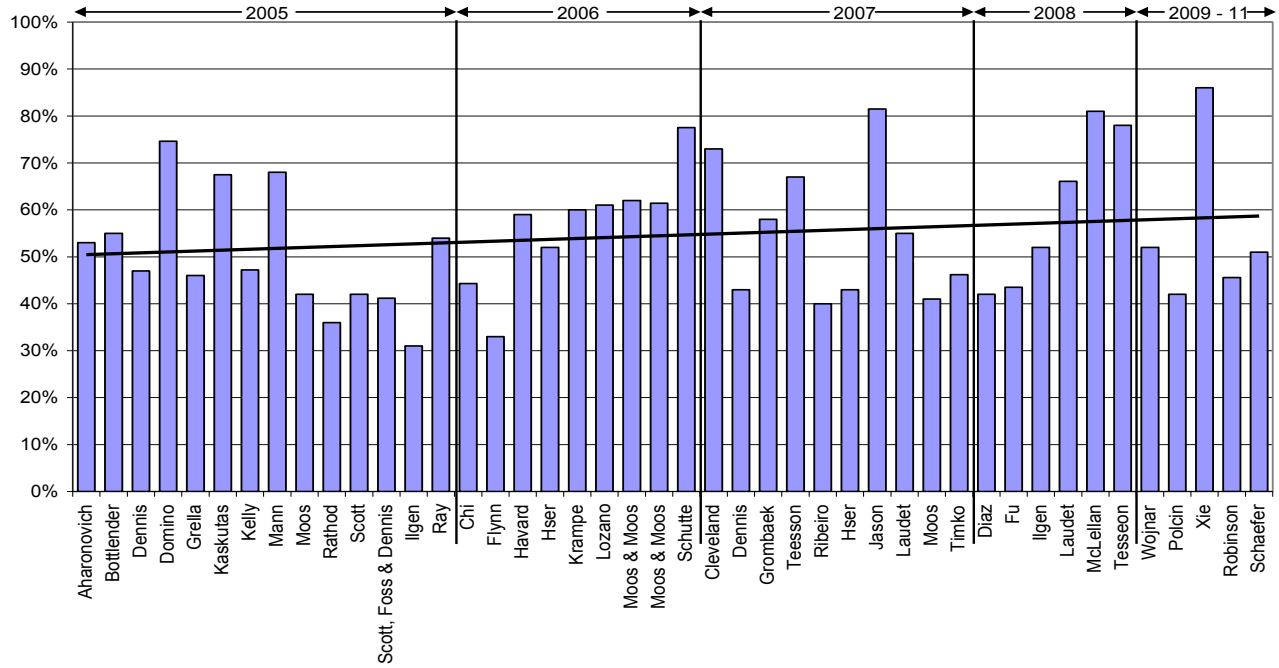


Figure 11 (following page) provides a summary of reported remission/recovery outcomes across six time periods. It becomes clear that the average reported remission rates were lowest in the 1960s (40.4%) and highest in the years 2005-2011 (54.6%).

The average recovery/remission rate for all 276 adult clinical studies (47.6%) is higher than the averages found in earlier reviews, partially due to distinctions between remission and abstinence reports and to inclusion in this analysis of a larger number of studies with shorter follow-up periods. Earlier analyses of treatment outcome studies and their reported remission or abstinence rates include: Bowman & Jellinek,[94] 27.5%; Hunt et al.,[95] 20%; Emrick,[96] 39.6%;

---

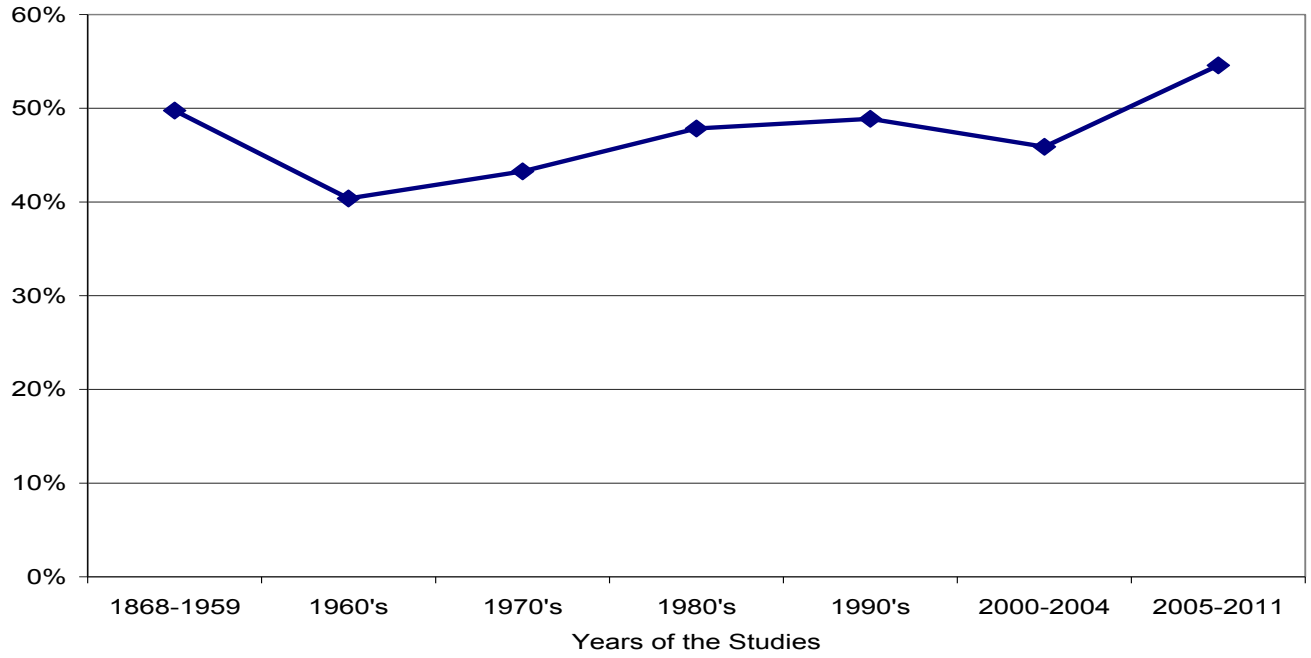
[94] Bowman, K.M. & Jellinek, E.M. (1941). Alcohol addiction and its treatment, *Quarterly Journal of Studies on Alcohol*, 2, 98-176.

[95] Hunt, W. A., Barnett, L. W., & Branch, L. G. (1971). Relapse rates in addiction programs. *Journal of Clinical Psycholo*gy, *27*, 455-456.

[96] Emrick, C.D. (1975). A review of psychologically oriented treatment of alcoholism. II. The relative effectiveness of different treatment approaches and the effectiveness of treatment versus no treatment. *J. Stud. Alcohol*, 36, 88.

Costello,[97] 26%; Walters,[98] 26.2%; Miller et al.,[99] 34.5%; Prendergast et al.,[100] 57%; and Monahan & Finney,[101] 43%.

Figure 11: Reported Remission Rates by Era



[97] Costello, R. M., Biever, P., & Baillargeon, J. G. (1977). Alcoholism treatment programming: Historical trends and modern approaches. *Alcoholism: Clinical and Experimental Research*, *1*, 311-318.

[98] Walters, G. D. (2000). Spontaneous remission from alcohol, tobacco and other drug abuse: Seeking quantitative answers to qualitative questions. *American Journal of Drug and Alcohol Abuse*, *26*, 443-460.

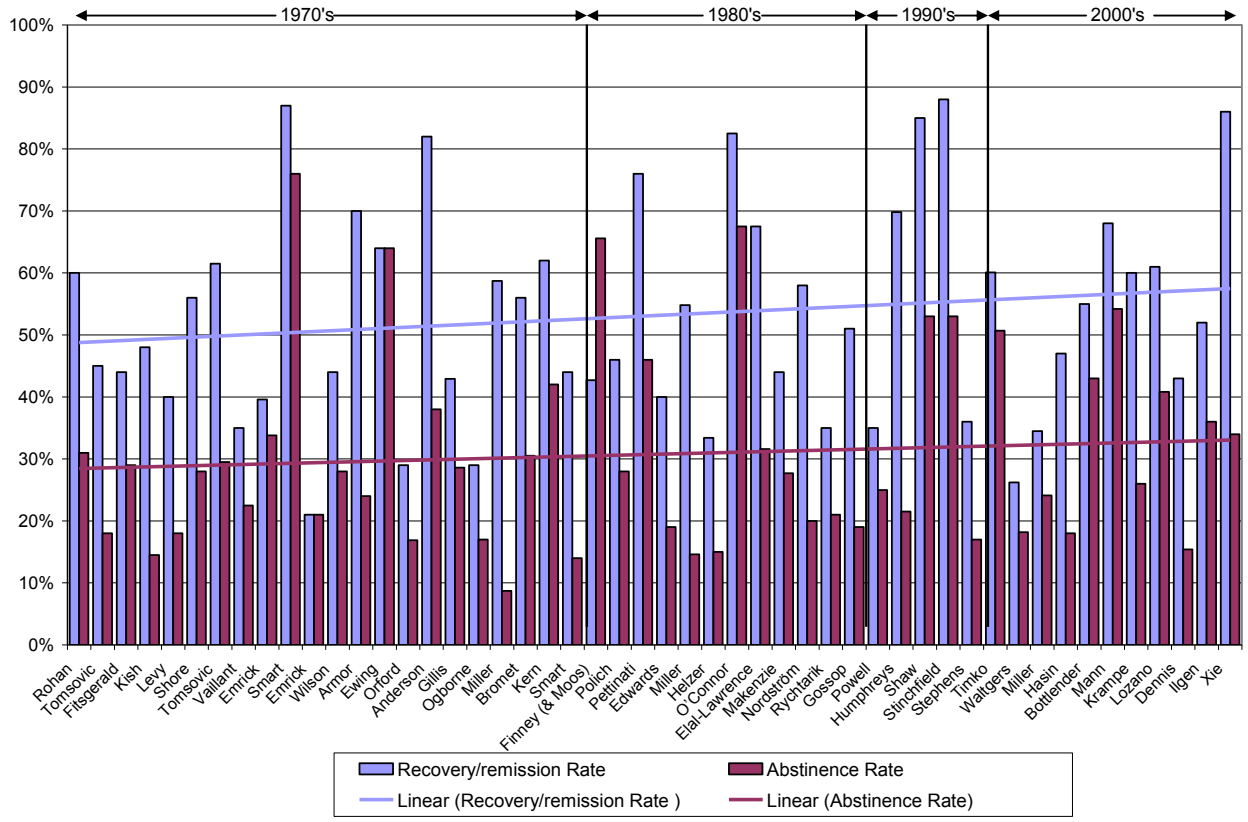
[99] Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol, 62*(2), 211-220.

[100] Prendergast, M. L., Podus, D., Chang, E., & Urada, D. (2002). The effectiveness of drug abuse treatment: A meta-analysis of comparison group studies. *Drug and Alcohol Dependence*, *67*, 53-72.

[101] Monahan, S. C., & Finney, J. W. (1996). Explaining abstinence rates following treatment for alcohol abuse: A quantitative synthesis of patient, research design and treatment effects. *Addiction*, *91*, 787-805.

For those concerned that many of the studies reported provided data on remission rates but none on rates of abstinence, 50 published studies were identified since 1970 that reported both remission rates (percentages of persons no longer meeting diagnostic criteria for substance use disorders at follow-up) and abstinence rates (alcohol or drug abstinence for a prescribed period prior to follow-up, or continuous abstinence from initial intervention until final follow-up). Data from those 50 studies are displayed in Figure 12.

Figure 12: Remission/Recovery Rates at Last Follow-up and Abstinence Rates, 1970s – 2000s (Average of 53.0% in remission and 30.8% abstinent)



As noted above, the average remission rate for all 276 adult studies was 49.8%. In the 50 studies reporting remission and abstinence rates, the average remission rate was 52.1% and the average abstinence rate was 30.3%. The 21.8% difference between the two reflects the proportion of persons in clinical studies who are reported to be using alcohol and/or other drugs asymptomatically or are experiencing problems that do not meet diagnostic criteria for

substance use disorders. This is comparable to the report by Sobell & Sobell[102] that, when people who have resolved alcohol problems are solicited for participation in research studies via newspaper ads or other media outlets, approximately 20% will have resolved their drinking problems via decelerated patterns of use.

Caution should be used in interpreting these rates. Based on the 1992 National Longitudinal Alcohol Epidemiologic Study, Dawson[103] reported that 49.9% of persons in remission from lifetime alcohol dependence had been drinking without symptoms or episodes of intoxication in the past year. However, in a subsequent follow-up, Dawson and colleagues[104] found that 51% of the asymptomatic risk drinkers had re-experienced symptoms of alcohol use disorders (compared to 27.7% of low-risk drinkers and 7.3% of abstainers), underscoring the need for long-term follow-up to calculate rates of sustainable recovery. These studies collectively affirm that deceleration of the frequency and intensity of drinking is a viable strategy for some problem drinkers, but that there is risk in destabilization of this strategy over time.

Remission rates and patterns of resumed use are remarkably similar across multiple drug choices (including nicotine),[105] although remission from opioid addiction appears to be less stable and durable than other patterns of remission.[106] Data from the National Epidemiologic Survey on Alcohol and Related Conditions confirm that the probability of remission varies somewhat by type of drug dependence but rises with years of use across drug choices.[107]

---

[102] Sobell, M. B., & Sobell, L. C. (1991). Recovery from alcohol problems without treatment. In N. Heather, W. R. Miller, & J. Greeley (Eds.), *Self control and the addictive behaviors* (pp. 198-242). New York: Maxwell Macmillan.

[103] 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.

[104] Dawson, D. A., Goldstein, R. B., & Grant, B. F. (2007). Rates and correlates of relapse among individuals in remission from DSM-IV alcohol dependence: A 3-year follow-up. *Alcoholism: Clinical and Experimental Research*, *31*(12), 2036-2045.

[105] Hunt, W. A., Barnett, L. W., & Branch, L. G. (1971). Relapse rates in addiction programs. *Journal of Clinical Psychol*ogy, *27*, 455-456.

[106] Calabria, B., Degenhardt, L., Briegleb, C., Vos, T., Hall, W. Lynskey, M.,…McLaren, J. (2010). Systematic review of prospective studies investigating "remission" from amphetamine, cannabis, cocaine or opioid dependence. *Addictive Behaviors, 35*, 741-749. 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. Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*, 503-508. Simpson, D. D., Joe, G. W., Lehman, W. E. K., & Sells, S. B. (1986). Addiction careers: Etiology, treatment and 12-year follow-up outcomes. *Journal of Drug Issues*, *16*, 107-121. Simpson, D. D., & Marsh, K. L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. M. Tims & C. G. Leukefeld (Eds.), *Relapse and recovery in drug abuse* (NIDA Research Monograph 72, DHHS Publication No. 88-1473, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.

[107] Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106*(3), 657-669.

Table 10: Remission Probabilities by Drug Choice and Duration of Use[108]

Type of Drug Dependence	Remission Probability in Year One	Remission Probability in First Decade	Remission Probability in Lifetime
Nicotine	3%	18.4%	83.7%
Alcohol	3%	37.4%	90.6%
Cannabis	4.7%	66.2%	97.2%
Cocaine	8.6%	75.8%	99.2%

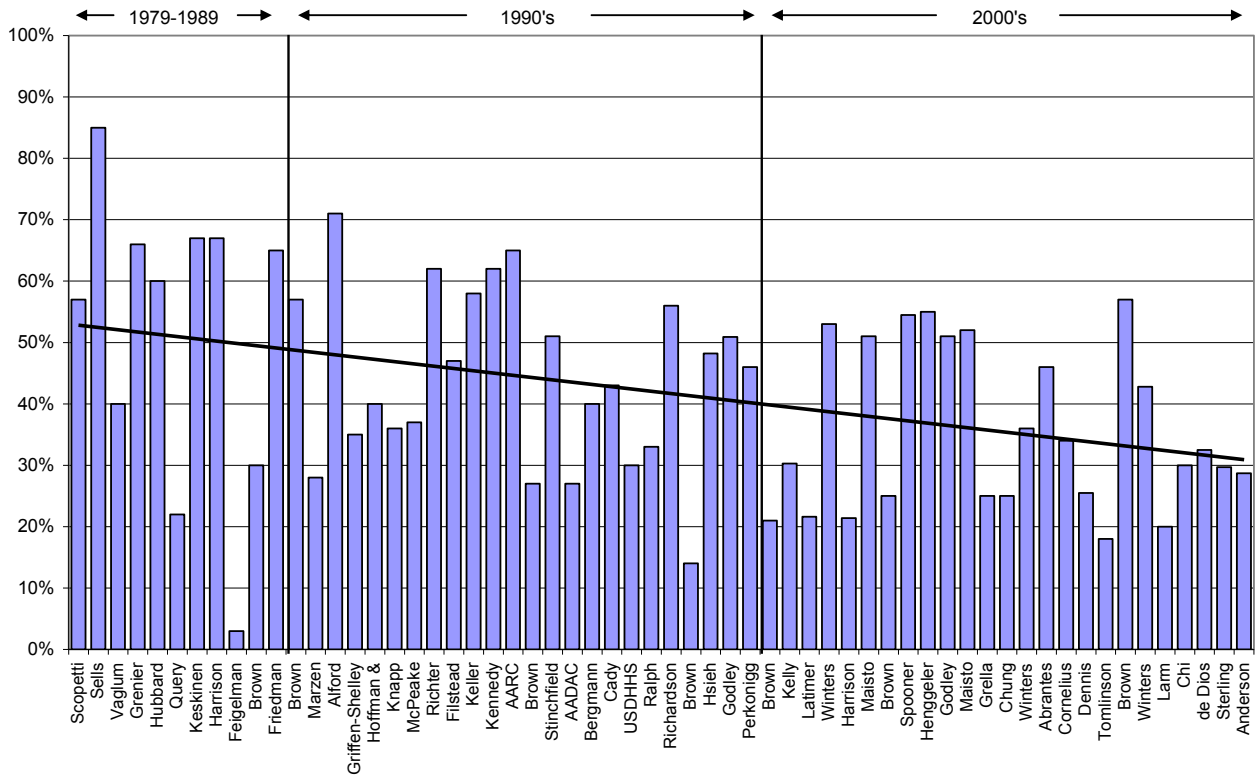
CLINICAL STUDIES (ADOLESCENT RECOVERY RATES)

Determining recovery/remission rates for those treated for substance use disorders is more difficult with adolescents than with adults for a variety of reasons, including the fact that adolescent studies are more likely to report outcomes in terms of reduced substance use (and report these in non-quantitative terms, e.g., "improved," "significant decreases") rather than in terms of rates of abstinence or percentages of subjects no longer meeting diagnostic criteria for substance use disorders.

A total of 60 follow-up studies were identified that reported recovery outcomes following the specialized treatment of adolescent substance use disorders. Across these 60 studies spanning four decades, the average recovery/remission rate is 42%. The studies analyzed here were further subdivided into those with sample sizes greater than 300 and those with follow-up periods of five or more years (as proxies for greater methodological rigor). There was an average recovery/remission rate of 44% in the 17 studies with samples greater than 300, and an average recovery/remission rate of 42.5% in the 8 studies with follow-up periods of five years or greater. The data from these studies are presented in more detail in Appendix C, which incorporates data from adolescent treatment outcomes studies presented in reviews conducted by Williams and Chang (2000), who, in their review of 53 adolescent substance use treatment outcome studies, found an average 6-month sustained abstinence rate of 38% and an average 12-month abstinence rate of 32%.

[108] Source: Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106*(3), 657-669.

Figure 13: Reported Recovery Outcomes in the Treatment of Adolescent Substance Use Disorders



The 20-percentage-point drop in average reported recovery success for adolescents over the course of the past three decades might be attributed to multiple factors: an actual change in these rates, improved methodological sophistication of outcome studies (calculating rates based on intent-to-treat rather than on "graduates," validation of self-reports via drug testing, higher rates of follow-up, longer follow-up periods, etc.), greater severity of adolescent AOD problems (e.g., earlier age of onset, greater drug potency, multiple drug use), and changes in case mix (with higher levels of community resources addressing less severe AOD problems more effectively, so that greater proportions of the adolescents who need specialized treatment would be those with greater problem severity/complexity/chronicity).

The studies analyzed here were further subdivided into those with sample sizes greater than 300 and those with follow-up periods of five or more years (as proxies for greater methodological rigor). The 17 studies with sample sizes greater than 300 showed an average

recovery/remission rate of 44%.[109] Those studies that followed adolescents at least 5 years after their treatment episodes averaged a reported 42.5% recovery/remission rate.[110] This might

[109] Sells, S. B., & Simpson, D. D. (1979). Evaluation of treatment outcome for youths in drug abuse reporting program (DARP): A follow-up study. In G. M. Beschner & A. S. Friedman (Eds.), *Youth drug abuse: Problems, issues, and treatment* (pp. 571-628). Lexington, MA: DC Heath. Harrison, P. A., & Hoffman, N. G. (1987). *CATOR 1987 report. Adolescent residential treatment: Intake and follow-up findings*. St. Paul, MN: Chemical Abuse/Addiction Treatment Outcome Registry. Friedman, A. S., Schwartz, R., & Utada, A. (1989). Outcome of a unique youth drug abuse program: A follow-up study of clients of the Straight, Inc. *Journal of Substance Abuse Treatment*, *6*, 259-268. Hoffman, N. G., & Kaplan, R. A. (1991). *CATOR Report: One-year outcome results for adolescents. Key correlates and benefits of recovery*. St. Paul, MN: CATOR/New Standards. Filstead, W. J. (1992). Treatment outcome: An evaluation of adult and youth treatment services. In J. W. Langerbucher, B. S. McCrady, W. Frankenstein, & P. E. Nathan (Eds.), *Annual review of addictions research and treatment* (Vol 2, p. 249-278). New York: Pergamon Press. AADAC (1995). *Adolescent treatment: Excellence through evaluation*. Calgary: Alberta Alcohol and Drug Abuse Commission, Government of Alberta, Canada. Bergmann, P. E., Smith, M. B., & Hoffman, N. G. (1995). Adolescent treatment: Implications for assessment, practice guidelines, and outcome management. *Pediatric Clinics of North America*, *42*, 453-472. Hsieh, S., Hoffman, N. G., & Hollister, D. C. (1998). The relationship between pre-, during-, post-treatment factors, and adolescent substance abuse behaviors. *Addictive Behaviors*, *23*, 477-488. Perkonigg, A., Lieb, R., Hofler, M., Schuster, P., Sonntag, H., & Wittchen, H. U. (1999). Patterns of cannabis use, abuse and dependence over time: Incidence, progressions and stability in a sample of 1228 adolescents. *Addiction*, *94*, 1663-78. Harrison, P. A., & Asche, S. (2001). Adolescent treatment for substance use disorders: Outcomes and outcome predictors. *Journal of Child & Adolescent Substance Abuse*, *11*(2), 1-17. Grella, C. E., Hser, Y.-I., Joshi, V., & Rounds-Bryant, J. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. *Journal of Nervous and Mental Disease*, *189*, 384-392. Chung, T., Martin, C. S., Grella, C. E., Winters, K. C., Abrantes, A. M., & Brown, S. A. (2003). Course of alcohol problems in treated adolescents. *Alcoholism: Clinical and Experimental Research*, *27*, 253-261. Dennis, M. L., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., & Donadlson, J.,…Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment*, *27*, 197-213. Godley, S. H., Dennis, M. L, Godley, M. D., & Funk, R. R. (2004). Thirty-month relapse trajectory cluster groups among adolescents discharged from out-patient treatment. *Addiction*, *99*(Suppl. 2), 129-139. Larm, P., Hodgins, S, Larsson, A., Samuelson, Y. M., & Tengstrom, A. (2008). Long-term outcomes of adolescents treated for substance misuse. *Drug and Alcohol Dependence*, *96*, 79-89. Chi, F. W., Kaskutas, L. A., Sterling, S., Campbell, C. I., & Weisner, C. (2009). Twelve-step affiliation and 3-year substance use outcomes among adolescents: Social support and religious service attendance as potential mediators. *Addiction*, *104*, 927-939. de Diois, M. A., Vaughan, E. L., Stanton, C. A., & Niaura, R. (2009). Adolescent tobacco use and substance abuse treatment outcomes. *Journal of Substance Abuse Treatment*, *37*, 17-24.

[110] Sells, S. B., & Simpson, D. D. (1979). Evaluation of treatment outcome for youths in drug abuse reporting program (DARP): A follow-up study. In G. M. Beschner & A. S. Friedman (Eds.), *Youth drug abuse: Problems, issues, and treatment* (pp. 571-628). Lexington, MA: DC Heath. Vaglum, P., & Fossheim, I. (1980). Differential treatment of young abusers: A quasi-experimental study of therapeutic community in a psychiatric hospital. *Journal of Drug Issues*, *10*, 505-516. Marzen, T. J. (1990). The effectiveness of an adolescent rehabilitation program for alcohol and other drug addictions in a San Francisco hospital: A 5 year follow-up study. *Dissertations Abstracts International*, *51*, 2979-A. Richardson, D. W. (1996). Drug rehabilitation in a treatment farm setting: The Nitawgi experience, 1978-1990. *Journal of Development & Behavioral Pediatrics*, *17*, 258-261. Winters, K. C., Stinchfield, R. D., Opland, E. O., Weller, C., & Latimer, W. W. (2000). The effectiveness of the Minnesota Model approach in the treatment of adolescent drug abusers.

well suggest that reported recovery rates rise in tandem with methodological improvements in the conduct of adolescent treatment follow-up studies—the opposite of what might be expected.

MEASURING RECOVERY PREVALENCE IN PHILADELPHIA

As part of its goal to evaluate its recovery-focused system-transformation efforts, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services collaborated in adding recovery-focused questions to the bi-annual health survey of Philadelphia and its six surrounding counties conducted by the Public Health Management Corporation. The purpose was to evaluate changes in recovery prevalence and attitudes toward treatment and recovery over time. Three questions related to recovery prevalence were included in the 2010 survey.

Question 1: Did you once have an alcohol or other drug problem that is no longer a problem in your life? 11.4% of Philadelphia respondents answered this question in the affirmative, compared to 7.5% of adults in the suburban counties surrounding Philadelphia.[111]

Question 2: Is there another person in your household or family who once had a significant or major problem with alcohol or other drugs who is now in recovery from that problem? 17.2% of Philadelphia respondents answered this question in the affirmative.[112]

Question 3: Do you personally know someone outside your immediate family who is in recovery from alcohol or other drug problems? 28.8% of Philadelphia respondents answered this question in the affirmative.[113]

These data are being analyzed to obtain a more detailed understanding of the profile of persons and families in recovery within the city of Philadelphia, and of the ways in which recovery status and knowing someone in recovery affects attitudes toward addiction treatment and recovery and the perception of quality of treatment within the city of Philadelphia. The data are also being analyzed by zip code to compare recovery prevalence, recovery support resources, and alcohol and other drug problem indices for each neighborhood in the City. The long-term goal is to establish the capacity to measure changes in annual rates of recovery

---

Addiction, *94*(4), 601-612. Chung, T., Martin, C. S., Grella, C. E., Winters, K. C., Abrantes, A. M., & Brown, S. A. (2003). Course of alcohol problems in treated adolescents. *Alcoholism: Clinical and Experimental Research*, *27*, 253-261. Anderson, K. G., Ramo, D. E., Cummins, K. M., & Brown, S. A. (2010). Alcohol and drug involvement after adolescent treatment and functioning during emerging adulthood. *Drug and Alcohol Dependence*, *107*, 171-181.

[111] Public Health Management Corporation Community Health Data Base: 2010 Southeast Pennsylvania Household Health Survey.

[112] Public Health Management Corporation Community Health Data Base: 2010 Southeast Pennsylvania Household Health Survey.

[113] Public Health Management Corporation Community Health Data Base: 2010 Southeast Pennsylvania Household Health Survey.

initiation and changes in overall recovery prevalence over time (i.e., the total number of people who have initiated and maintained their recovery status).

Discussion

Limitations: Before we explore the major conclusions that can be drawn from this analysis, it is important to review the limitations of the data presented.

A majority of the studies reported only outcomes related to the course of substance use, without reference to broader arenas of psychosocial functioning. Of necessity, the rates reported here focus specifically on substance use disorder remission or substance use abstinence, rather than on broader dimensions that have come to be understood as essential elements of the recovery process.

The search methodology did not ensure identification of every previous study reporting a recovery outcome, and many modern studies could not be included because they report outcomes in formats (e.g., percentage of days using for complete samples) that could not be converted to either remission or abstinence rates. This report does, however, present the largest number of studies included in an analysis of recovery rates.

The rates were based on widely varying definitions of recovery—from the most common categories of DSM remission-to-abstinence to less uniform categories, e.g., marked improvement, improvement. Even the abstinence rates reported varied in meaning, from continuous abstinence since treatment to abstinence for a set period prior to follow-up, or abstinence at the time of follow-up. Wherever possible, we clarify this influence by reporting outcomes for both remission and abstinence.

A few of the earliest recovery rates reported were based on expert estimates rather than actual studies. Average rates for later studies (those published since 2000) were included to evaluate the potential influence of these early studies on the average recovery rate reported for all studies.

Studies varied widely in their research methodologies, particularly in variations in sample sizes, duration of follow-up, and follow-up rates for the original samples. An effort was made to evaluate this potential bias by reporting recovery rates for studies with sample sizes greater than 300 and studies that followed participants for five or more years.

Particularly problematic were studies that reported outcomes in terms of increases or decreases in drug use (e.g., percentage of days using or abstinent in the past 30 days) within the total sample, without referencing the percentage of the sample that was abstinent, free of AOD-related problems, or no longer meeting DSM criteria for substance use disorders.[114] Also problematic for this analysis were studies that reported outcomes using scales that could not easily be converted to post-treatment remission or abstinence rates. There were many such studies that could not be included in this analysis. It is unclear how these studies might have influenced the reported averages in this report if their data had been reported in terms of precise

[114] e.g., Zywiak, W. H., Longabuagh, R., & Wirtz, P. (2002). Decomposing the relationships between pretreatment social network characteristics and alcohol treatment outcomes. *Journal of Studies on Alcohol*, *63*, 114-121.

percentages of samples abstinent or in remission. (Studies listed in the references that do not appear in the figures usually fell into this type of reporting.)

Recap and Discussion of Major Findings: The primary intent of most of the studies reviewed here was to assess the prevalence of AOD problems or to compare one treatment approach to another. Only recently has the field witnessed studies that focused specifically on recovery prevalence and/or recovery status separate and distinct from the issue of treatment evaluation. The large number of studies cited here should not divert attention from the fact that recovery-focused research has yet to come of age as a legitimate branch of addiction studies.

We set out at the beginning of this paper to answer five questions related to recovery prevalence and recovery rates. To answer those questions, we reviewed 415 scientific studies of recovery outcomes (79 community studies, 276 adult clinical studies, and 60 adolescent clinical studies) conducted with clinically and culturally diverse populations in multiple countries over the past century. In summary, this is what we discovered.

1. How many persons are in recovery from AOD problems in the United States?

This question was answered by extrapolating national estimates from the major governmental surveys of the course of alcohol and other drug use and related problems (including the Epidemiologic Catchment Area Study, the National Comorbidity Survey, the National Health Interview, the National Longitudinal Alcohol Epidemiologic Survey, and the National Epidemiologic Survey on Alcohol and Related Conditions) and from a 2010 recovery survey conducted by the Public Health Management Corporation in Philadelphia, Pennsylvania and six surrounding counties. Based on this analysis, the percentage of adults in the general population in the United States in remission from substance use disorders ranges from 5.3% to 15.3%. These rates produce a conservative estimate of the number of adults in remission from significant alcohol or drug problems in the United States at more than 25 million people, with a potential range from 25-40 million (not including those in remission from nicotine dependence alone).

2. What percentage of people who develop AOD problems eventually achieve recovery?

Of adults surveyed in the general population who once met lifetime criteria for a substance use disorder, an average of 49.9% no longer meet those criteria (53.9% in studies conducted since 2000). In community studies reporting both remission rates and abstinence rates for substance use disorders, an average of 43.5% with such disorders in their lifetime achieved remission, but only 17.9% did so through a strategy of complete abstinence. The high prevalence of non-abstinent remissions in community populations is related to the less severe, less complex, and less prolonged AOD problems experienced in community populations compared to those problems found among people entering addiction treatment in the United States.

3. What is the rate of recovery for persons whose problems are severe enough to warrant specialized professional treatment?

In an analysis of 276 addiction treatment follow-up studies of adult clinical samples, the average remission/recovery rate across all studies was 47.6% (50.3% in studies published since 2000). The average remission/recovery rates within those studies with sample sizes of 300 or more and studies with a follow-up period of five or more years—two factors used as a proxy for more methodologically sophisticated studies—were 46.4% and 46.3%, respectively.

In the 50 adult clinical studies reporting remission and abstinence rates, the average remission rate was 52.1% and the average abstinence rate was 30.3%. The 21.8% difference reflects the proportion of persons in post-treatment follow-up studies who, based on available information, are using alcohol and/or other drugs asymptomatically or are experiencing only subclinical problems (not severe enough to meet diagnostic criteria for substance use disorders). It is unclear to what extent such patterns of reduced use constitute a permanent state, a state of respite prior to re-addiction, or a transition phrase that precedes and increases the chances of later abstinence (as has been found with similar patterns that precede smoking cessation).[115]

The rate of remission achieved through sustained deceleration of AOD consumption rather than abstinence declines as problem severity and length of follow-up increase,[116] although some cases of moderated remission are found even among high-severity populations monitored over the course of years.[117]

Miller and Joyce[118] found that 88.8% of patients rated either abstinent or controlled maintained that status at one year, and Miller[119] found that 91% of patients who had achieved

---

[115] Institute of Medicine (2007). *Ending the tobacco problem: A Blueprint for the nation*. Washington, D.C.: The National Academies Press, p. 94.; also see Evans, N., Gilpin, E., Pierce, J.. Burns, D., Borland, M. & Bal, D. (1992). Occasional smoking among adults: Evidence from the California Tobacco Survey. *Tobacco Control*, 1, 169-175.

[116] Moos & Finney 1981 Moos, R. H., & Moos, B. S. (2006a). Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction*, *101*, 212-222. Pattison, E. M., Headley, E. B., Gleser, G. C., & Gottschalk, L. A. (1968). Abstinence and normal drinking: An assessment of change in drinking patterns to alcoholics after treatment. *Quarterly Journal of Studies on Alcohol*, *29*, 610-633. Smart, R. (1978). Characteristics of alcoholics who drink socially after treatment. *Alcoholism: Clinical and Experimental Research, 2*, 49-52. Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051.

[117] Armor, D. J,. & Meshkoff, J. E. (1983). Remission among treated and untreated alcoholics. In N. K. Mello (Ed.), *Advances in substance abuse: Behavioral and biological research: Volume 3* (pp. 239-269). Greenwich, CT: JAI Press. Cunningham, J. (1999). Untreated remission from drug use: The predominant pathway. *Addictive Behaviors*, *24*(2), 267-270. Edwards, G. (1985). A later follow-up of a classic case series: D.L. Davies 1962 report and its significance for the present. *Journal of Studies on Alcohol*, *46,* 181-190. Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051.

[118] Miller, W. R., & Joyce, M. A. (1979). Prediction of abstinence, controlled drinking, and heavy drinking outcomes following behavioral self-control training. *Journal of Consulting and Clinical Psychology*, *47*, 773-775.

[119] Miller, W. R. (1978). Behavioral treatment of problem drinkers: A comparative outcome study of three controlled drinking therapies. *Journal of Consulting and Clinical Psychology*, *46*, 74-86.

controlled drinking at 3 months maintained that status at one-year follow-up, but others have documented deterioration in the stability of controlled drinking beyond the one-year point. Self- or collateral report of controlled drinking in early follow-up is not a predictor of controlled drinking at long-term follow-up, but early abstinence is a predictor of better long-term outcomes (both abstinence and asymptomatic drinking).[120] The probability of achieving sustained asymptomatic use following periods of problematic use declines as problem severity and duration increase.[121] Early post-treatment moderate drinkers have a higher relapse rate than those who begin drinking moderately after a sustained period of abstinence.[122]

Early abstinence following treatment indicates increased likelihood of future positive prognosis (either by abstinence or asymptomatic drinking), but early moderation does not predict either moderation or abstinence at later follow-up.[123] Maisto and colleagues[124] found that moderated drinking at year 1 following treatment did not predict successful moderate drinking at year 3. In Vaillant's long-term follow-up study,[125] only 36% of men initially identifying as controlled drinkers were able to sustain that control over all of the follow-up periods. Cycling between controlled drinking and problematic drinking was common in the long-term Vaillant study; fluctuation rather than steady progression may be the most prevalent pattern in community populations. In Vaillant's[126] 60-year follow-up of alcoholic men, only 4 of the 21 men drinking in a controlled manner at age 50 were able to sustain controlled drinking at follow-up at age 70. Valliant[127] concluded that abstinence is more stable over time than controlled drinking and argued that "return to controlled drinking, as reported in short-term studies, is often a mirage" (p. 1050). The studies of other researchers confirm that conclusion.[128]

---

[120] Miller, W. R., Leckman, A. L., Delaney, H. D., & Tinkcom, M. (1992). Long-term follow-up of behavioral self-control training. *Journal of Studies on Alcohol*, *3*, 249-261. Rychtarik, R. G., Foy, D. W., Scotyt, T., Lokey, L., & Prue, D. M. (1987). Five-six-year follow-up of broad spectrum behavioral treatment for alcoholism: Effects of training controlled drinking skills. *Journal of Consulting and Clinical Psychology*, *55*, 106-108.

[121] Miller, W. R., Leckman, A. L., Delaney, H. D., & Tinkcom, M. (1992). Long-term follow-up of behavioral self-control training. *Journal of Studies on Alcohol*, *3*, 249-261.

[122] Finney, J. W., & Moos, R. (1981). Characteristics and prognosis of alcoholics who become moderate drinkers and abstainers after treatment. *Journal of Studies on Alcohol, 42,* 94-105.

[123] Rychtarik, R. G., Foy, D. W., Scotyt, T., Lokey, L., & Prue, D. M. (1987). Five-six-year follow-up of broad spectrum behavioral treatment for alcoholism: Effects of training controlled drinking skills. *Journal of Consulting and Clinical Psychology*, *55*, 106-108.

[124] Maisto, S. A., Clifford, P. R., Stout, R. L., & Davis, C. M. (2006). Drinking in the year after treatment as a predictor of three-year drinking outcomes. *Journal of Studies on Alcohol*, *67*, 823-832.

[125] Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*, 243-249.

[126] Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051.

[127] Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051.

[128] Finney, J. W., & Moos, R. (1981). Characteristics and prognosis of alcoholics who become moderate drinkers and abstainers after treatment. *Journal of Studies on Alcohol, 42,* 94-105. Pettinati, H. M., Sugarman, A. A., DiDonata, N., & Maurer, H. S. (1982). The natural history of alcoholism over four years after treatment. *Journal of Studies on Alcohol*, *43*, 201-205. Xie, H., Drake, R. E., McHugo, G. J., Xie, L., & Mohandas, A. (2010). The 1-year course of remission, abstinence and recovery in dual diagnosis. *Journal of Substance Abuse Treatment*, *39*, 132-140.

The prognosis for remission via decelerated drinking rises when people are younger, have lower levels of problem severity and chronicity, and have fewer overall problems.[129] Hasin, Liu, and Paykin[130] did a one-year follow-up on persons with untreated DSM-IV alcohol dependence. While drinking reductions were common in the group as a whole, no subject with 6 or 7 dependence symptoms at baseline had sustained a pattern of drinking reduction, whereas 56.5% of those who had only three symptoms had sustained such reductions for a one-year period. Style of remission also differs by duration of remission. Of those in remission more than 5 years, the percentage in abstinence-based remission rises in tandem with length of remission.[131]

The overall outcomes of the clinical studies reported here must be viewed in light of Moyer and Finney's[132] finding (across 29 studies) that persons in no-treatment conditions (wait list, sought but did not receive treatment, placebo) showed an average abstinence rate of 21% at follow-up. Comparison of our average reported abstinence rate (30.3%) with the 21% abstinence rate at follow-up for those in a no-treatment condition reveals an added effect for those who have received addiction treatment.

Treatment does play an important role in remission from more severe drug problems. Cunningham[133] found that, among adults living in the community who had experienced remission from drug dependence, the percentage with past treatment ranged from 43.1% for cannabis dependence to 90.7% for heroin dependence (with remission from other drug dependencies falling within this range). In community surveys of remission from alcohol problems over the life course, most (including 77% in two Canadian surveys) do so without formal treatment, but those who have received treatment report having had much more severe alcohol problems.[134]

Miller, Walters, and Bennett[135] reviewed 7 of the largest multi-site trials of alcoholism treatment in the US and concluded:

> …we believe the data justify, as a conservative estimate, the "rule of thirds": that a year after a single treatment event, one third, on average, remain in full remission and at least another third evidence substantial improvement.[136]

---

[129] Miller, W. R. (1983). Controlled drinking: A history and critical review. *Journal of Studies on Alcohol*, *44*, 68-83.

[130] Hasin, D., Liu, X., & Paykin, A. (2001). DSM-IV alcohol dependence and sustained reduction in drinking: Investigation in a community sample. *Journal of Studies on Alcohol*, *62,* 509-517.

[131] 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.

[132] Moyer, A., & Finney, J. W. (2002). Outcomes for untreated individuals involved in randomized trials of alcohol treatment. *Journal of Substance Abuse Treatment*, *23*(2), 247-252.

[133] Cunningham, J. A. (2000). Remissions from drug dependence: Is treatment a prerequisite? *Drug and Alcohol Dependence*, *59*, 211-213.

[134] Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. *American Journal of Public Health*, *86*(7), 966-972.

[135] Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol, 62*(2), 211-220.

The data presented in this paper suggest an even more optimistic view of remission/recovery prognosis and the role professional treatment can play in the resolution of severe AOD problems. This optimism is particularly appropriate when those in need of treatment are able to get an adequate dose of treatment. Among treated individuals, recovery prognosis is related to treatment dose, with those in remission averaging a longer duration of treatment than those still addicted.[137] The under-dosing of addiction treatment may be viewed as analogous to sub-therapeutic doses of antibiotics that may produce temporary symptom suppression but not lasting recovery.

4. Does the rate of recovery for adolescents following treatment differ from that of adults who seek specialized addiction treatment?

This analysis compares 276 adult addiction treatment outcome studies conducted between 1868 and 2011 with 60 adolescent addiction treatment outcome studies conducted between 1979 and 2011. The average recovery/remission rate following specialty treatment reported in the adolescent studies was 42% (35% average for those studies conducted since 2000) compared to an average recovery/remission rate of 47.6% reported in the adult studies (50.3% average for those studies conducted since 2000). The 42% average reported for adolescents is comparable to similar reviews, e.g., Sussman's finding of 30-40% post-treatment abstinence rates for adolescents across multiple studies and points of time.[138] Of the 60 adolescent studies examined, the average rates in the two more methodologically rigorous studies (those with sample sizes of 300 or greater and those with follow-up periods of 5 years or longer, as crude proxies for enhanced rigor) are 44% and 42.5%, respectively. Interpretation of these findings should be tempered by the greater number of adult studies and the greater sample sizes and much longer follow-up periods in the adult studies. While the high percentage of adolescents who report some AOD use in the months following treatment is discouraging, studies of longer trajectories of AOD use confirm post-treatment increases in abstinence, reductions in use, and gains in global health of treated adolescents. There is cause for optimism regarding long-term prospects for recovery from substance use disorders. Adolescent recovery rates rise in tandem with treatment completion and participation in continuing care activities—two potential target areas for increasing the quality and effectiveness of adolescent treatment.[139]

---

[136] Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol, 62*(2), 211-220.

[137] Flynn, P. M., Joe, G. W., Broome, K. M., Simpson, D. D., & Brown, B. S. (2003). Recovery from opioid addiction in DATOS. *Journal of Substance Abuse Treatment*, *25*(3), 177-186.

[138] Sussman, S. (2010). A review of Alcoholics Anonymous/Narcotics Anonymous for Teens. *Evaluation & the Health Professions*, 33(1), 26-55.

[139] Williams, R. J., & Chang, S. Y. (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcome. *Clinical Psychology: Science and Practice*, *7*(2), 138-166. Winters, K. C., Stinchfield, R., Latimer, W. W., & Lee, S. (2007). Long-term outcome of substance-dependent youth following 12-step treatment. *Journal of Substance Abuse Treatment*, *33*, 61-69.

5. *How can local communities establish baseline recovery prevalence data that can be used to guide and evaluate recovery-focused systems-transformation efforts?*

Local communities can integrate recovery prevalence questions into regular community health surveys to track changes in recovery prevalence over time as a means of evaluating community-wide strategies for addressing AOD problems. A model for potential replication is the integration of recovery prevalence questions into the bi-annual community health survey conducted in the city of Philadelphia and surrounding counties by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services and the Public Health Management Corporation. Such baseline data are being used there, and could be used in other communities in similar ways, to guide recovery-focused systems-transformation efforts and to evaluate planned interventions in particular geographical areas, e.g., evaluating service needs by zip codes/planning areas and matching treatment/recovery support resources to those areas of greatest problem severity and lowest levels of recovery capital.

CONCLUSIONS AND RECOMMENDATIONS

Instability in the Course of AOD Problems and Their Resolution:

Short-term studies of addiction can mask the complex course of this disorder by conveying prognoses that are overly optimistic (e.g., the assumption that short periods of abstinence or remission are naturally sustainable) or overly pessimistic (e.g., the assumption that persons resuming AOD use following treatment will all revert to symptomatic use and further escalation of problem severity). Periods of abstinence as long as 3 months are among the prevailing features of addiction careers and should not be interpreted as sustainable recovery or as evidence that professional help or peer support is not indicated.[140] In Vaillant's[141] long-term follow-up of Harvard undergraduates and inner-city adolescents, 41% of those with two years of abstinence relapsed; 5-6 years predicted the stability point of long-term abstinence. Only 9% of Vaillant's sample with 5 years of abstinence subsequently returned to drinking, and none did after 6 years of abstinence. Short periods of symptomatic use, asymptomatic use, and abstinence are all part of the natural course of addiction. Distinguishing recovery initiation from respites within an addiction career is possible only within a longer time perspective.[142] There is considerable turnover and transitioning back and forth between problem and non-problem AOD use.[143]

---

[140] Schuckit, M. A., Tipp, J. E., & Bucholz, K. K. (1997). Periods of abstinence following onset of drug dependence in 1,853 men and women. *Journal of Studies on Alcohol*, *58*, 581-589.

[141] Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*, 243-249.

[142] Gottheil, E. Thornton, C. C., Skoloda, T. E., & Alterman, A. I. (1982). Follow-up of abstinent and nonabstinent alcoholics. *American Journal of Psychiatry*, *139*, 560-565. Vaillant, G. E. (1983). *The natural history of alcoholism: Causes, patterns, and paths to recovery*. Cambridge, MA: Harvard University Press.

[143] Clark, W. B. (1976). Loss of control, heavy drinking and drinking problems in a longitudinal study. *Journal of Studies on Alcohol*, *37*(9), 1256-1290.

Addiction and recovery both are best viewed as fluid rather than fixed states, but buried within this fluidity is a natural momentum toward remission and recovery. Even the most chronic, intractable patterns of addiction contain opportunities for full recovery,[144] and buried within even the most seemingly solid recoveries lie vulnerabilities for reactivation of active addiction.[145] This fluidity underscores the need for sustained and assertive recovery management.

For most people, AOD problems are neither persistent nor progressive.[146] Even when prolonged alcohol- and drug-related problems seem to be escalating to the point of no return, forces are accumulating that increase the probability of recovery.[147] This remission/recovery momentum exists in both the presence and the absence of professional treatment.[148]

Windows of Opportunity for Early Re-intervention:

Of those who resume AOD use following treatment, most do so in the first days or weeks—with 60-80% of those returning to use doing so in the first 90 days after treatment.[149] In one major treatment follow-up study,[150] 34% of those treated returned to AOD use within 3 days

---

[144] Vaillant, G. E., Clark, W., Cyrus, C., Milofsky, E. S., Kop, J., Wulsin, V. W., & Mogielnicki, N. P. (1983). Prospective study of alcoholism treatment: Eight-year follow-up. *American Journal of Medicine*, *75*, 455-463.

[145] White, W., & Schulstad, M. (2009). Relapse following prolonged addiction recovery: Time for answers to critical questions. *Counselor*, *10*(4), 36-39.

[146] Booth, B. M., Fortney, S. M., Forteny, J. C., Curran, G. M., & Kirchner, J. E. (2001). Short-term course of drinking in an untreated sample of at-risk drinkers. *Journal of Studies on Alcohol*, *62*, 580-588. Ray, M. (1961). The cycle of abstinence and relapse among heroin addicts. *Social Problems, 9*, 132-140. Ray, M. B. (1968). Abstinence cycles and heroin addicts. In E. Rubington & M. Weinberg (Eds.), *Deviance: The interactitionist perspective* (pp. 484-492). London: Macmillan. Scott, C. K., Foss, M. A., & Dennis, M. L. (2005). Pathways in the relapse-treatment-recovery cycle over 3 years. *Journal of Substance Abuse Treatment*, *28*(Supplement 1), S63-S72. Schuckit, M. A., Tipp, J. E., & Bucholz, K. K. (1997). Periods of abstinence following onset of drug dependence in 1,853 men and women. *Journal of Studies on Alcohol*, *58*, 581-589. Watson, C. G., & Pucel, J. (1985). The consistency of posttreatment alcoholics' drinking patterns. *Journal of Consulting and Clinical Psychology*, *53,* 679-683.

[147] Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. *Journal of Studies on Alcohol*, *60*, 437-447.

[148] Moyer, A., & Finney, J. W. (2002). Outcomes for untreated individuals involved in randomized trials of alcohol treatment. *Journal of Substance Abuse Treatment*, *23*(2), 247-252.

[149] Hubbard, R. L., & Marsden, M. E. (1986). Relapse to use of heroin, cocaine and other drugs in the first year after treatment. In *Relapse and recovery in drug abuse* (NIDA Research Monograph 72, pp. 247-253). Rockville, MD U.S. Government Printing Office. Hunt, W. A., Barnett, L. W., & Branch, L. G. (1971). Relapse rates in addiction programs. *Journal of Clinical Psycholo*gy, *27*, 455-456. Gossop, M., Green, L. Phillips, G., & Bradley, B. P. (1989). Lapse, relapse and survival among opiate addicts after treatment: A prospective follow-up study. *British Journal of Psychiatry*, *154*, 348-353. Simpson, D. D., & Sells, S. B. (1990). *Opioid addiction and treatment: A 12-year follow-up*. Malabar, FL.: Krieger. Stephens, R., & Cottrell, E. (1972). A follow-up study of 200 narcotic addicts committed for treatment under the Narcotic Addict Rehabilitation Act (NARA). *British Journal of Addiction*, *67*, 45-53.

[150] Gossop, M., Marsden, J., Stewart, D. & Tracy, S. (2002). Change and stability of change after treatment for drug misuse: two year outcomes from the National Treatment Outcome Research Study. *Addictive Behaviors*, 27, 155-166.

of treatment discharge, 45% within 7 days, and 50% within 14 days. These data underscore the potential value in assertive approaches to post-treatment monitoring, support, and early re-intervention for both adults[151] and adolescents.[152] However, it should be noted that not all of those who return to use escalate back to levels of severity meeting diagnostic criteria; Some return to abstinence, and others maintain asymptomatic use.[153] Of those who resume use following an abstinence effort, as many as half do not return to dependent use in follow-up periods of less than five years.[154] Given this variability of outcome, all persons completing treatment should be provided assertive mechanisms of post-treatment monitoring and support.

Role of Community In Recovery:

The effects of brief professional interventions on long-term recovery outcomes are more ephemeral than the more enduring roles of family and social support.[155] Recovery prevalence is influenced by personal and family factors, but also by broader historical, cultural, political, and economic influences that contribute to the wide disparity in resources and opportunities available to those who have developed severe AOD problems.[156] This suggests that recovery prevalence is shaped as much by community recovery capital as by the personal recovery capital of each community's citizenry.

Solution Perspective versus Problem Perspective:

Scientific studies of the long-term resolution of alcohol and other drug problems have been relegated to the realm of afterthought in the alcohol/drug problems research arena. Substantial benefits could accrue from studying the prevalence, pathways, stages, and styles of

---

[151] 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. Dennis, M. L., & Scott, C. K. (in press). Four-year outcomes from the early re-intervention (ERI) experiment using recovery management check-ups. *Drug and Alcohol Dependence*. McKay, J. R (2009). *Treating substance use disorders with adaptive continuing care.* Washington, D.C.: American Psychological Association.

[152] Godley, M., Godley, S., Dennis, M., Funk, R., & Passetti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21-32.

[153] Orford, J., Oppenheimer, E., & Edwards, G. (1976). Abstinence or control: The outcome for excessive drinkers two years after consultation. *Behaviour Research and Therapy*, *14*, 409-418.

[154] Gossop, M., Marsden, J., Stewart, D. & Tracy, S. (2002). Change and stability of change after treatment for drug misuse: two year outcomes from the National Treatment Outcome Research Study. *Addictive Behaviors*, 27, 155-166. Gossop, M., Stewart, D., Browne, N. & Marsden, J. (2002). Factors associated with abstinence, lapse or relapse to heroin use following residential treatment: Protective effects of coping responses. *Addiction*, 97(10), 1259-1267.

[155] Moos, R.H. (1994). Why do some people recovery from alcohol dependence, whereas others continue to drink and become worse over time? *Addiction,* 89, 31-34; Moos, R.H. (1994). Editorial: Treated or untreated, an addiction is not an island to itself. *Addiction*, 89, 507-509.

[156] Blomqvist, J. (2002). Recovery with and without treatment: A comparison of resolutions of alcohol and drug problems. *Addiction Research & Theory*, *19*(2), 119-158.

long-term recovery, but these have not, until recently, been a subject of focused attention. Much of the data available about recovery in this analysis was extracted from the study of other issues, e.g., studies of the duration of treatment effects, relapse rates, and mortality rates. It is time for focused attention on the lived solutions to AOD problems at personal, family, organizational, community, and cultural levels.

Definition and Measurement:

Challenges in defining and measuring recovery from significant alcohol and other drug problems can be overcome to generate national, regional, state, and local recovery prevalence data for purposes of planning, resource allocation, and program- and system-wide performance evaluation. The establishment of such a recovery-focused database should be a high priority at national, state, and local levels.

Recovery Mobilization:

There is a significant population of individuals and families in recovery from alcohol and other drug problems in the United States who could be mobilized more widely to support prevention and early intervention programs, serve as volunteers in addiction treatment and recovery support programs, and provide leadership of AOD-related policy advocacy initiatives. Those who were once part of the problem constitute an underutilized resource in the search for fresh solutions to America's alcohol and other drug problems.

Recovery Momentum:

Recovery momentum varies by problem severity and by social capital. Vaillant[157] found that socially disadvantaged men with severe alcohol dependence have a greater likelihood of stable remission than college-educated men exhibiting chronic alcohol abuse. Mild and severe problem severity generate their own momentum toward remission; Moderate problem severity combined with social advantage minimizes pressure towards remission. Studies of clinical populations suffering from severe, prolonged addictions—and selective media coverage of these same populations—create a pessimistic portrayal of the prospects for long-term recovery. "Insanity," prolonged institutionalization, and death are not the normative outcomes of AOD problems. Recovery, rather than continual addiction or inevitable relapse, is the natural long-term course for substance use disorders.[158] Recovery is not an aberration achieved by a small morally enlightened minority. If there is a natural developmental momentum in the course of

---

[157] Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051.

[158] Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Addiction*, *106*(3), 657-669. Price, R. K., Risk, N. K., & Spitznagel, E. L. (2001). Remission from drug abuse over a 25 year period: Patterns of remission and treatment use. *American Journal of Public Health, 91*, 1107-1113. Watson, C. G., & Pucel, J. (1985). The consistency of posttreatment alcoholics' drinking patterns. *Journal of Consulting and Clinical Psychology*, *53,* 679-683.

AOD problems, it is toward remission and recovery. The probability of stable abstinence increases with age but is not inevitable: Substance use disorders may persist for decades without remission or deceleration.[159] The central problem is not making recovery possible—that is already a reality. It is instead the long duration of time between problem and intervention onset and successful recovery stabilization and maintenance—and the significant harm that can accrue to individuals, families, and communities in the interim.

Key Questions and Challenges:

Recovery from a substance use disorder is more the norm than an anomaly. Given what we know about recovery prevalence and the natural momentum toward recovery, the central research, clinical, and policy questions are:

- What characteristics of the adolescent, family, treatment milieu, and community environment promote or inhibit the achievement of long-term recovery?
- What strategies can be used to enhance the resolution of less severe AOD problems (via the elevation of community recovery capital) without the need for professional interventions?
- How can addiction careers be prevented, quickly aborted, or shortened—and recovery careers extended—to reduce addiction's toll on the individual, family, workplace, community, and society?
- What professional and peer support interventions can successfully elevate recovery outcomes for those with the greatest problem severity/complexity/chronicity and the least recovery capital?
- How can recovering people and their families be mobilized to break intergenerational cycles of AOD problem transmission and to serve as a healing force within their local communities and the country as a whole?

These questions lie at the center of the movement to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management for individuals, families, and communities.

[159] Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043-1051. Hser, Y.I. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study, *Journal of Addictive Diseases*, 26(1), 51-60.

References

Please Note: Those with an asterisk (*) are studies included in the analysis.

*AADAC (1995). Adolescent treatment: Excellence through evaluation. Calgary: Alberta Alcohol and Drug Abuse Commission, Government of Alberta, Canada.

*AARC (1994). An evaluation of Alberta Adolescent Recovery Centre. Synergy Research Group, Calgary.

*Aharonovich, E., Lu, X., Samet, S., Nunes, E., Waxman, R., & Hasin, D. (2005). Postdischarge cannabis use and its relationship to cocaine, alcohol, and heroin use: A prospective study. American Journal of Psychiatry, 162, 1507-1514.

*Alford, G. S., Koehler, R. A., & Leonard, J. (1991). Alcoholics Anonymous-Narcotics Anonymous model inpatient treatment of chemically dependent adolescents: A 2-year outcome study. Journal of Studies on Alcohol, 52, 118-126.

*Allen, J., Lowman, C., & Miller, W.R. (1996). Perspectives on precipitants of relapse. Addiction, 91(Supplement), pp. S3-S4. doi:10.1080/09652149638755

*Anderson, K. G., Ramo, D. E., Cummins, K. M., & Brown, S. A. (2010). Alcohol and drug involvement after adolescent treatment and functioning during emerging adulthood. Drug and Alcohol Dependence, 107, 171-181. doi:10.1016/j.drugalcdep.2009.10.005

*Anderson, W., & Ray, O. (1977). Abstainers, non-destructive drinkers and relapsers: One year after a four-week inpatient group-oriented alcoholism treatment program. In F. Sexias (ed.), Currents in alcoholism (Vol. II., pp. 511-523). New York: Grune & Stratton, Inc.

*Andre, C., Jaber-Filho, J. A., Carvalho, M., Jullien, C., & Hoffman, A. (2003). Predictors of recovery following involuntary hospitalization of violent substance abuse patients. American Journal on Addictions, 12(1), 84-89. doi:10.1080/10550490390143394

*Anglin, M. D., Brecht, M. L., Woodward, J. A., & Bonett, D. G. (1986). An empirical study of maturing out: Conditional factors. International Journal of the Addictions, 21, 233-246.

*Anglin, M. D., Hser, Y., & Grella C. E. (1997). Drug addiction and treatment careers among clients in DATOS. Psychology of Addictive Behaviors, 11, 308-323. doi:10.1037/0893-164X.11.4.308

*Anthony, J. C., Warner, L. A., & Kessler, R. C. (1994). Comparative epidemiology of dependence on tobacco, alcohol, controlled substances and inhalants: Basic findings from the National Comorbidity Survey. Experimental and Clinical Psychopharmacology, 2(3), 244-268.

*Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. Psychiatric Rehabilitation Journal, 24(2), 159-168.

*Armor, D. J,. & Meshkoff, J. E. (1983). Remission among treated and untreated alcoholics. In N. K. Mello (Ed.), Advances in substance abuse: Behavioral and biological research: Volume 3 (pp. 239-269). Greenwich, CT: JAI Press.

*Armor, D. J., Polich, J. M., & Stambul, H. B. (1978). Alcoholism and treatment. New York: Wiley.

*Babor, T. F., Longabaugh, R., Zweben, A. Fuller, R. K., Sout, R. L., Anton, R. F., & Randall, C. L. (1994). Issues in the definition and measurement of drinking outcomes in alcoholism treatment research. Journal of Studies on Alcohol, Supplement 12, 101-111.
*Bacchus, L, Strang, J., & Watson, P. (2000). Pathways to abstinence: Two-year follow-up data on 60 abstinent former opiate addicts who had been turned away from treatment. European Addiction Research, 6, 141-147. doi:10.1159/000019026
*Bagnall, D. (1991). Alcohol and drug use in a Scottish cohort: 10 years on. British Journal of Addiction, 86, 895-904. doi:10.1111/j.1360-0443.1991.tb01845.x
*Bailey, M. B., & Stewart, J. (1967). Normal drinking by persons reporting previous problem drinking. Quarterly Journal of Studies on Alcohol, 28, 305-315.
Ball, J. C., & Ross, A. (1991). The effectiveness of methadone maintenance programs: patients, programs, services and outcomes. New York: Springer-Verlag.
*Ball, J. C., & Snarr, R. N. (1969). A test of the maturation hypothesis with respect to opiate addiction. UN Bulletin on Narcotics, 21(4), 9-13.
*Barchha, R., Stewart, M. A., & Guze, S. B. (1968). The prevalence of alcoholism among general hospital ward patients. American Journal of Psychiatry, 125, 681-684. doi:10.1176/appi.ajp.125.5.681
*Bartels, S. J., Drake, R. E., & Wallach, M. A. (1995). Long-term course of substance use disorders among patients with severe mental illness. Psychiatric Services, 46, 248-251.
*Bergmann, P. E., Smith, M. B., & Hoffman, N. G. (1995). Adolescent treatment: Implications for assessment, practice guidelines, and outcome management. Pediatric Clinics of North America, 42, 453-472.
*Beseler, C. L., Aharonovich, E., Keys, K. M., & Hasin, D. S. (2008). Adult transition from at-risk drinking to alcohol dependence: The relationship of family history and drinking motives. Alcoholism: Clinical and Experimental Research, 32, 607-616. doi:10.1111/j.1530-0277.2008.00619.x
*Bess, B., Janus, S., & Rifkin, A. (1972). Factors in successful narcotics renunciation. American Journal of Psychiatry, 128(7), 861-865. doi:10.1176/appi.ajp.128.7.861
*The Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. Journal of Substance Abuse Treatment, 33, 221-228. doi:10.1016/j.jsat.2007.06.001
*Biernacki, P. (1986). Pathways from heroin addiction: Recovery without treatment. Philadelphia: Temple University Press.
*Bischof, G., Rumpf, H. J., Hapke, U., Meyer, C., & John, U. (2002). Natural recovery from alcohol dependence: How restrictive should our definition of treatment be? Journal of Studies on Alcohol, 63, 229-236.
Bischof, G., Rumpf, H. J., Myer, C., Hapke, U., & John, U. (2004). What triggers remission without formal help from alcohol dependence? Findings from the TACOS-Study. In P. Rosenqvist, J. Blomqvist, A. Koski-Jannes, & L. Ojesjo (eds.), Addiction and life course. NAD Monograph No. 44 (pp. 85-101). Helsinki Finland: Nordic Council for Alcohol and Drug Research.
*Blomqvist, J. (2002). Recovery with and without treatment: A comparison of resolutions of alcohol and drug problems. Addiction Research & Theory, 19(2), 119-158. doi:10.1080/16066350290017248

*Bloomberg, W. (1939). Treatment of chronic alcoholism with amphetamine (Benzedrine) sulfate. New England Journal of Medicine, 220, 129-135.
*Bond, J., Kaskutas, L. A., & Weisner, C. (2003). The persistent influence of social networks and Alcoholics Anonymous on abstinence. Journal of Studies on Alcohol, 64, 579-588.
*Booth, B. M., Fortney, S. M., Forteny, J. C., Curran, G. M., & Kirchner, J. E. (2001). Short-term course of drinking in an untreated sample of at-risk drinkers. Journal of Studies on Alcohol, 62, 580-588.
*Booth, P. G., Dale, B., Slade, P. D., & Dewey, M. E. (1992). A follow-up study of problem drinkers offered a goal choice option. Journal of Studies on Alcohol, 53, 594-600.
*Bottlender, M., & Soyka, M (2005). Outpatient alcoholism treatment: Predictors of outcome after 3 years. Drug and Alcohol Dependence, 80, 83-89. doi:10.1016/j.drugalcdep.2005.03.011
*Bowden, C. L., & Langenauer, B. J. (1972). Success and failure in the NARA addiction program. American Journal of Psychiatry, 128, 853-856. doi:10.1176/appi.ajp.128.7.853
*Bowen, W. T., & Androes, L. (1968). A follow-up study of 79 alcoholic patients: 1963-1965. Bulletin of the Menninger Clinic, 32, 26-34.
*Bowman, K. M., & Jellinek, E. M. (1941). Alcohol addiction and its treatment. Quarterly Journal of Studies on Alcohol, 2, 98-176.
*Brecht, M., von Mayrhauser, C., & Anglin, M. D. (2000). Predictors of relapse after treatment for methamphetamine use. Journal of Psychoactive Drugs, 32(2), 211-220.
*Brecht, M. L., Huang, D., Evans, E., & Hser, Y. I. (2008). Polydrug use and implications for longitudinal research: Ten-year trajectories for heroin, cocaine and methamphetamine users. Drug and Alcohol Dependence, 96, 193-201. doi:10.1016/j.drugalcdep.2008.01.021
*Brennan, P. L., Schutte, K. K., Moos, B., & Moos, R. H. (2011). Twenty-year alcohol-consumption trajectories of older men and women. Journal of Studies on Alcohol, 72, 308-321.
*Bromet, E., & Moos, R. (1979). Prognosis of alcoholic patients: Comparisons of abstainers and moderate drinkers. British Journal of Addiction, 74, 183-188. doi:10.1111/j.1360-0443.1979.tb02427.x
*Brown, S. A. (1993). Recovery patterns in adolescent substance abuse. In J. F. Baer, R. Marlatt, & J. McMahon (Eds.), Addictive behavior across the life span: Preventive treatment and policy issues. Beverly Hills, CA: Sage Publications.
*Brown, S. A., D'Amico, E. J., McCarthy, D. M., & Taggart, S. F. (2001). Four-year outcomes from adolescent alcohol and drug treatment. Journal of Studies on Alcohol, 62, 381-388.
*Brown, S. A., Mott, M. A., & Myers, M. A. (1990). Adolescent alcohol and drug treatment outcome. In R. R. Watson (Ed.), Drug and alcohol abuse prevention (pp. 373-403). Totowa, NJ: Humana.
*Brown, S. A., Myers, M. G., Mott, M. A., & Vik, P. W. (1994). Correlates of success following treatment for adolescent substance abuse. Applied and Preventive Psychology, 3, 61-73. doi:10.1016/S0962-1849(05)80139-8
*Brown, S. A., & Ramo, D. E. (2006). Clinical course of youth following treatment for alcohol and drug problems. In H. Liddle & C. Rowe (Eds.), Treating adolescent substance abuse: State of the science (pp. 79-103). Cambridge, UK: Cambridge University Press.

*Brown, S. A., Tapert, S. F., Tate, S. R., & Abrantes, A. M. (2000). The role of alcohol in adolescent relapse and outcome. Journal of Psychoactive Drugs, 32(1), 107-115.
*Brown, S. A., Vik, P. W., & Creamer, V. A. (1989). Characteristics of relapse following adolescent substance abuse treatment. Addictive Behaviors, 14, 291-300. doi:10.1016/0306-4603(89)90060-9
*Brunn, K. (1963). Outcome of different types of treatment for alcoholics. Quarterly Journal of Studies on Alcohol, 24, 280-288.
*Burleson, J. A., & Kaminer, Y. (2005). Self-efficacy as a predictor of treatment outcome in adolescent substance use disorders. Addictive Behaviors, 30, 1751-1764. doi:10.1016/j.addbeh.2005.07.006
*Burman, S. (1997). The challenge of sobriety: Natural recovery without treatment and self-help groups. Journal of Substance Abuse, 9, 41-61. doi:10.1016/S0899-3289(97)90005-5
*Cacciola, J. S., Dugosh, K., Folz, C., Leahy, P., & Stevens, R. (2005). Treatment outcomes: First time versus treatment-experienced clients. Journal of Substance Abuse Treatment, 28, S13-S22. doi:10.1016/j.jsat.2004.09.005
*Cady, M. E., Winters, K. C., Jordan, D. A., Solberg, K. B., & Stinchfield, R. D. (1996). Motivation to change as a predictor of treatment outcome for adolescent substance abusers. Journal of Child and Adolescent Substance Abuse, 5, 73-91. doi:10.1300/J029v05n01_04
*Cahalan, D., Cisin, I. H., & Crossley, H. M. (1969). American drinking practices: A national study of drinking behavior and attitudes. New Brunswick, NJ: Rutgers Center of Alcohol Studies.
*Cahalan, D., & Room R. (1970). Problem drinking among American men. New Brunswick, NJ: Rutgers Center of Alcohol Studies.
*Cahalan, D., & Room, R. (1972). Problem drinking among American men aged 21-59. American Journal of Public Health, 62, 1473-1482.
*Calabria, B., Degenhardt, L., Briegleb, C., Vos, T., Hall, W. Lynskey, M.,…McLaren, J. (2010). Systematic review of prospective studies investigating "remission" from amphetamine, cannabis, cocaine or opioid dependence. Addictive Behaviors, 35, 741-749. doi:10.1016/j.addbeh.2010.03.019
*Cameron, D., Manik, G., Bird, R., & Sinorwalia, A. (2002). What may we be learning from so-called spontaneous remission in ethnic minorities? Addiction Research and Theory, 10, 175-182. doi:10.1080/16066350290017257
*Carroll, K. M., Nich, C., Ball, S., McCance, E., & Rounsaville, B. (1998). Treatment of cocaine and alcohol dependence with psychotherapy and disulfram. Addiction, 93, 713-727. doi:10.1046/j.1360-0443.1998.9357137.x
*Carroll, K. M., & Rounsaville, B. J. (1992). Contrast of treatment-seeking and untreated cocaine abusers. Archives of General Psychiatry, 49, 464-471.
*Carroll, K. M., Rounsaville, B. J., Nich, C., Gordon, L. T., Wirtz, P. W., & Gawin, F. (1994). One-year follow up of psychotherapy and pharmacotherapy for cocaine dependence: Delayed emergence of psychotherapy effects. Archives of General Psychiatry, 51, 989-997.
*Carroll, S. (1993). Spirituality and purpose in life in alcoholism recovery. Journal of Studies on Alcohol, 54, 297-301.

*Center for Substance Abuse Treatment (CSAT). (2007). National Summit on Recovery: Conference Report (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.
*Chamberlain, H. (1891). Modern methods of treating inebriety. Chautaquan, 13, 494-499.
*Chermack, S., Blow, F., Gomberg, E. Mudd, S., & Hill, E. (1996). Older adult controlled drinkers and abstainers. Journal of Studies on Alcohol, 8, 453-462.
*Chi, F. W., Kaskutas, L. A., Sterling, S., Campbell, C. I., & Weisner, C. (2009). Twelve-step affiliation and 3-year substance use outcomes among adolescents: Social support and religious service attendance as potential mediators. Addiction, 104, 927-939. doi:10.1111/j.1360-0443.2009.02524.x
*Chi, F. W., Satre, D. D., & Weisner, C. (2006). Chemical dependency patients with cooccurring psychiatric diagnoses: Service patterns and 1-year outcomes. Alcoholism: Clinical and Experimental Research, 30(5), 851-859. doi:10.1111/j.1530-0277.2006.00100.x
*Christo, G., & Franey, C. (1995). Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes. Drug and Alcohol Dependence, 38, 51-56. doi:10.1016/0376-8716(95)01103-6
*Chung, T., Martin, C. S., Grella, C. E., Winters, K. C., Abrantes, A. M., & Brown, S. A. (2003). Course of alcohol problems in treated adolescents. Alcoholism: Clinical and Experimental Research, 27, 253-261. doi:10.1097/01.ALC.0000053009.66472.5E
*Clancy, J. (1961). Outpatient treatment of the alcoholic. Journal of the Iowa State Medical Society, 51, 221-226.
*Clancy, J., Vornback, R., & Vanderhoof, E. (1965). Treatment of alcoholics, a follow-up study. Diseases of the Nervous System, 26, 555-561.
*Clark, W. B. (1976). Loss of control, heavy drinking and drinking problems in a longitudinal study. Journal of Studies on Alcohol, 37(9), 1256-1290.
*Clark, W. B., & Cahalan, D. (1976). Changes in problem drinking over a four-year span. Addictive Behaviors, 1, 251-259. doi:10.1016/0306-4603(76)90018-6
*Cleveland, H. H., Harris, K. S., Baker, A. K., Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. Journal of Substance Abuse Treatment, 33, 13-23. doi:10.1016/j.jsat.2006.11.005
Cohen, P., Chen, H., Crawford, T. N., Brook, J. S., & Gordon, J. (2007). Personality disorders in early adolescence and the development of later substance use disorders in the general population. Drug and Alcohol Dependence, 88, S71-S84. doi:10.1016/j.drugalcdep.2006.12.012
*Cohen, P., & Cohen J. (1984). The clinician's illusion. Archives of General Psychiatry, 41, 1178-1182.
*Compton, W. I., Cottler, L. B., Jacobs, J. L., Ben-Abdallah, A., & Spitznagel, E. L. (2003). The role of psychiatric disorders in predicting drug dependence treatment outcomes. American Journal of Psychiatry, 160, 890-895.
*Compton, W. M., Thomas, Y. F., Stinson, F. S., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Archives of General Psychiatry, 64(5), 566-576.

*Cornelius, J. R., Maisto, S. A., Pollock, N. K., Martin, C. S., Salloum, I. M. Lynch, K. G., & Clark, D. B. (2003). Rapid relapse generally follows treatment for substance use disorders among adolescents. Addictive Behaviors, 28, 381-386. doi:10.1016/S0306-4603(01)00247-7

*Corwin, E., & Cunningham, E. (1944). Institutional facilities for the treatment of alcoholism. Quarterly Journal of Studies on Alcohol, 5(1), 9-85.

Costello, E. J., Sung, M., Worthman, C., & Angold, A. (2007). Pubertal maturation and the development of alcohol use and abuse. Drug and Alcohol Dependence, 88, S50-S59. doi:10.1016/j.drugalcdep.2006.12.009

*Costello, R. M., Biever, P., & Baillargeon, J. G. (1977). Alcoholism treatment programming: Historical trends and modern approaches. Alcoholism: Clinical and Experimental Research, 1, 311-318. doi:10.1111/j.1530-0277.1977.tb05787.x

*Cottrell, D., Childs-Clarke, A., & Ghodse, A. H. (1985). British opiate addicts: An 11 year follow-up. British Journal of Psychiatry, 146, 448-450. doi:10.1192/bjp.146.4.448

*Cross, G., Morgan, C., Mooney, A., Martin, C., & Rafter, J. (1990). Alcoholism treatment: A ten-year follow-up study. Alcoholism Clinical and Experimental Research, 14, 169-173. doi:10.1111/j.1530-0277.1990.tb00465.x

*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.

*Cunningham, J. A. (1999a). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. Journal of Studies on Alcohol, 60, 463-466.

*Cunningham, J. A. (1999b). Untreated remissions from drug use: The predominant pathway. Addictive Behaviors, 24(2), 267-270. doi:10.1016/S0306-4603(98)00045-8

*Cunningham, J. A. (2000). Remissions from drug dependence: Is treatment a prerequisite? Drug and Alcohol Dependence, 59, 211-213. doi:10.1016/S0376-8716(99)00123-4

*Cunningham, J. A., Koski-Jannes, A., & Toneatto, T. (1999). Why do people stop their drug use? Results from a general population sample. Contemporary Drug Problems, 26, 695-710.

*Cunningham, J. A., Lin, E., Ross, H. E., & Walsh, G. W. (2000). Factors associated with untreated remissions from alcohol abuse or dependence. Addictive Behaviors, 25, 317-321. doi:10.1016/S0306-4603(98)00130-0

*Curran, G. M. & Booth, B. M. (1999). Longitudinal changes in predictor profiles of abstinence from alcohol use among male veterans. Alcoholism: Clinical and Experimental Research, 23, 141-143. doi:10.1111/j.1530-0277.1999.tb04035.x

*D'Amico, E. J., Ramchand, R., & Miles, J. N. V. (2009). Seven years later: Developmental transitions and delinquent behavior for male adolescents who received long-term substance treatment. Journal of Studies on Alcohol, 70, 641-651.

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, 34(2), 109-120. doi:10.1007/s11414-007-9053-7

*Davies, D. L. (1962). Normal drinking in recovered alcohol addicts. Quarterly Journal of Studies on Alcohol, 23, 94-104.

*Davies, D. L., Shepherd, M., & Myers, E. (1956). The two-years' prognosis of 50 alcohol addicts after treatment in hospital. Quarterly Journal of Studies on Alcohol, 17, 485-502.
*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. doi:10.1111/j.1530-0277.1996.tb01685.x
*Dawson, D. A. (1998). Symptoms and characteristics of individuals with different types of recovery from DSM-IV alcohol dependence. Journal of Substance Abuse, 10, 127-142. doi:10.1016/S0899-3289(99)80129-1
*Dawson, D. A., Goldstein, R. B., & Grant, B. F. (2007). Rates and correlates of relapse among individuals in remission from DSM-IV alcohol dependence: A 3-year follow-up. Alcoholism: Clinical and Experimental Research, 31(12), 2036-2045. doi:10.1111/j.1530-0277.2007.00536.x
*Dawson, D. A., Grant, B. F., Stinson, F. S., & Chou, P. S. (2006). Estimating the effect of help-seeking on achieving recovery from alcohol dependence. Addiction, 101, 824-834. doi :10.1111/j.1360-0443.2006.01433.x
*Dawson, D. A., Grant, B. F., Stinson, F. S., & Chou, P. S. (2006). Maturing out of alcohol dependence: The impact of transitional life events. Journal of Studies on Alcohol, 67, 195-203.
*Dawson, D. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. Addiction, 100(3), 281-292. doi:10.1111/j.1360-0443.2004.00964.x
*Dawson, D. ., Li, T.-K., Chou, P., & Grant, B. F. (2009). Transitions in and out of alcohol use disorders: Their associations with conditional changes in quality of life over a 3-year follow-up interval. Alcohol and Alcoholism, 44, 84-92. doi:10.1093/alcalc/agn094
*Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol-use disorders. Journal of Studies of Alcohol and Drugs, 69, 866-877.
*De Bruijn, C., van den Brink, W., de Graaf, R., & Vollebergh, W. A. (2006). The three-year course of alcohol use disorders in the general population: DSM-IV, ICD-10 and the craving withdrawal model. Addiction, 101, 385-392. doi :10.1111/j.1360-0443.2006.01327.x
*de Diois, M. A., Vaughan, E. L., Stanton, C. A., & Niaura, R. (2009). Adolescent tobacco use and substance abuse treatment outcomes. Journal of Substance Abuse Treatment, 37, 17-24. doi:10.1016/j.jsat.2008.09.006
*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. doi:10.1177/0193841X07307771
*Dennis, M. L., Godley, S. H., Diamond, G., Tims, F. M., Babor, T., & Donadlson, J.,…Funk, R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. Journal of Substance Abuse Treatment, 27, 197-213. doi:10.1016/j.jsat.2003.09.005
*Dennis, M. L., & Scott, C. K. (in press). Four-year outcomes from the early re-intervention (ERI) experiment using recovery management check-ups. Drug and Alcohol Dependence.

*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. doi:10.1016/S0149-7189(03)00037-5

*Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. Journal of Substance Abuse Treatment, 28(Supplement 1), S51-S62. doi:10.1016/j.jsat.2004.10.013

*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. doi:10.1111/j.1530-0277.1989.tb00406.x

*Dias, A. C., Ribeiro, M., Dunn, J., Sesso, R., & Laranjeira, R. (2008). Follow-up study of crack cocaine users: Situations of the patients after 2, 5, and 12 years. Substance Abuse, 29(3), 71-79. doi:10.1080/08897070802218125

*Domino, K. B., Hornbein, T. F., Polissar, N. L., Renner, G., Johnosn, J., Alberti, S., & Hankes, L. (2005). Risk factors for relapse in health care professionals with substance use disorders. Journal of the American Medical Association, 293(12), 1453-1460. doi:10.1001/jama.293.12.1453

*Donovan, J. E., Jessor, R., & Jessor, L. (1983). Problem drinking in adolescence and young adulthood: A follow-up study. Journal of Studies on Alcohol, 44, 109-137.

*d'Orban, P. T. (1974). A follow-up study of female narcotic addicts: Variables related to outcome. British Journal of Psychiatry, 125, 28-33. doi:10.1192/bjp.125.1.28

*Dorus, W., Ostrow, D. G., Anton, R., Cushman, P., Collins, J. F., Schaefer, M.,…Sathers, M. R. (1989). Lithium treatment of depressed and nondepressed alcoholics. Journal of the American Medical Association, 262, 1646-1652. doi:10.1001/jama.1989.03430120100029

*Drake, R. E., Mueser, K. T., Clark, R. E., & Wallach, M. A. (1996). The course, treatment, and outcome of substance disorder in persons with severe mental illness. American Journal of Orthopsychiatry, 66, 42-51. doi:10.1037/h0080153

Duffy, S. Q., Cowell, A. J., Council, C., & Shi, W. (2006). Formal treatment, self-help, or no treatment for alcohol-use disorders? Evidence from the National Household Survey on Drug Abuse. Journal of Studies on Alcohol, 67, 363-372.

*DuPont, R. L., McLellan, A. T., White, W. L., Merlo, L. J. & Gold, M. S. (2009). Setting the standard for recovery: Physicians' Health Programs. Journal of Substance Abuse Treatment, 36, 159-171. doi:10.1016/j.jsat.2008.01.004

*Duvall, H. J., Lock, B. Z., & Brill, L. (1963). Followup study of narcotic drug addicts five years after hospitalization. Public Health Reports, 78, 185-194.

*Edens, E. L., Glowinski, A. L., Grazier, K. L., & Bucholz, K. K. (2008). The 14-year course of alcoholism in a community sample: Do men and women differ? Drug and Alcohol Dependence, 93, 1-11. doi:10.1016/j.drugalcdep.2007.08.013

*Edwards, G. (1966). Hypnosis in treatment of alcohol addiction: Controlled trial, with analysis of factors affecting outcome. Quarterly Journal of Studies on Alcohol, 27, 221-241.

*Edwards, G. (1984). Drinking in longitudinal perspective: Career and natural history. British Journal of Addiction, 79, 175-183. doi:10.1111/j.1360-0443.1984.tb00260.x

*Edwards, G. (1985). A later follow-up of a classic case series: D.L. Davies's 1962 report and its significance for the present. Journal of Studies on Alcohol, 46, 181-190.

*Edwards, G., Oppenheimer, E., Duckitt, A., Sheehan, M., & Taylor, C. (1983). What happens to alcoholics? Lancet, 322, 269-271. doi:10.1016/S0140-6736(83)90245-3
*Edwards, G., & Guthrie, S. (1967). A controlled trial of inpatient and outpatient treatment of alcohol dependency. Lancet, 289, 555-559. doi:10.1016/S0140-6736(67)92129-0
*Edwards, G., Orford, J., Egert, S., Guthrie, S., Hawker, A., Hensman, C.,…Taylor, C. (1977). Alcoholism: A controlled trial of "treatment" and "advice". Journal of Studies on Alcohol, 38, 1004-1031.
*Elal-Lawrence, G., Slade, P. D., & Dewey, E. (1986). Predictors of outcome type in treated problem drinkers. Journal of Studies on Alcohol, 47, 41-47.
*Emrick, C. D. (1975). A review of psychologically oriented treatment of alcoholism. II. The relative effectiveness of different treatment approaches and the effectiveness of treatment versus no treatment. Journal of Studies on Alcohol, 36, 88-108.
*Evans, J. L., Hahn, J. A., Lum, P. J., Stein, E. S., & Page, K. (2009). Predictors of injection drug use cessation and relapse in a prospective cohort of young injection drug users in San Francisco, CA (UFO Study). Drug and Alcohol Dependence, 101, 152-157. doi:10.1016/j.drugalcdep.2008.12.007
*Ewing, J., & Rouse, B. (1976). Failure of an experimental treatment program to inculcate controlled drinking in alcoholics. British Journal of Addiction, 71, 123-134. doi:10.1111/j.1360-0443.1976.tb00069.x
*Ferguson, F. N. (1970). A treatment program for Navaho alcoholics: Results after four years. Quarterly Journal of Studies on Alcohol, 31, 898-919.
*Fillmore, K. M. (1974). Drinking and problem drinking in early adulthood and middle age: An exploratory 20-year follow-up study. Quarterly Journal of Studies on Alcohol, 35, 819-840.
*Fillmore, K. M. (1975). Relationship between specific drinking problems in early adulthood and middle age: An exploratory 20-year follow-up study. Journal of Studies on Alcohol, 36, 882-907.
*Fillmore, K. M., & Midanik, L. (1984). Chronicity of drinking problems among men: A longitudinal study. Journal of Studies on Alcohol, 45, 228-236.
*Filstead, W. J. (1992). Treatment outcome: An evaluation of adult and youth treatment services. In J. W. Langerbucher, B. S. McCrady, W. Frankenstein, & P. E. Nathan (Eds.), Annual review of addictions research and treatment (Vol 2, p. 249-278). New York: Pergamon Press.
*Finney, J. W., & Moos, R. (1981). Characteristics and prognoses of alcoholics who become moderate drinkers and abstainers after treatment. Journal of Studies on Alcohol, 42, 94-105.
*Finney, J. W., & Moos, R. H. (1991). The long-term course of treated alcoholism: I. Mortality, relapse and remission rates and comparison with community controls. Journal of Studies on Alcohol, 52, 44-54.
*Finney, J. W., Moos, R. H., & Mewborn, C. R. (1980). Posttreatment experiences and treatment outcome of alcoholic patients six months and two years after hospitalization. Journal of Consulting and Clinical Psychology, 48, 17-29. doi:10.1037/0022-006X.48.1.17

Finney, J. W., Moos, R. H., & Timko, C. (1999). Course of treated and untreated substance use disorders: Remission and resolution, relapse and mortality. In B. S. McCarty, & E. E. Epstein (Eds.), Addictions: A comprehensive guidebook (pp. 30-49). New York: Oxford University Press.

Fingfeld, D. L. (1997). Resolution of drinking problems without formal treatment. Perspectives in Psychiatric Care, 33(3), 14-23. doi:10.1111/j.1744-6163.1997.tb00544.x

*Fitzgerald, B. J., Pasewark, R. A., & Clark, R. (1971). Four-year follow-up of alcoholics treated at a rural state hospital. Quarterly Journal of Studies on Alcohol, 32, 636-642.

*Fleming, M. F., Barry, K. L., Manwell, L. B., Johnson, K., & London, R. (1997). Brief physician advice for problem drinkers: A randomized controlled trial in community-based primary care practices. Journal of the American Medical Association, 277, 1039-1045. doi:10.1001/jama.1997.03540370029032

*Flynn, P. M., Joe, G. W., Broome, K. M., Simpson, D. D., & Brown, B. S. (2003). Recovery from opioid addiction in DATOS. Journal of Substance Abuse Treatment, 25(3), 177-186. doi:10.1016/S0740-5472(03)00125-9

*Flynn, P. M., Joe, G. W., Broome, K. M., Simpson, D. D., & Brown, B. S. (2006). Looking back on cocaine dependence: Reasons for recovery. The American Journal on Addictions, 12, 398-411. doi:10.1111/j.1521-0391.2003.tb00483.x

*Foster, J. H., Peters, T. J., & Marshall, E. J. (2000). Quality of life measures and outcome in alcohol-dependent men and women. Alcohol, 22, 45-52. doi:10.1016/S0741-8329(00)00102-6

*Fox, V., & Smith, A. (1959). Evaluation of a chemopsychotherapeutic program for the rehabilitation of alcoholics: Observations over a two-year period. Quarterly Journal of Studies on Alcohol, 20, 767-780.

*Frawley, P., & Smith, J. (1992). One-year follow-up after multimodal inpatient treatment for cocaine and methamphetamine dependencies. Journal of Substance Abuse Treatment, 9, 271-286. doi:10.1016/0740-5472(92)90020-O

*Friedman, A. S., Schwartz, R., & Utada, A. (1989). Outcome of a unique youth drug abuse program: A follow-up study of clients of Straight, Inc. Journal of Substance Abuse Treatment, 6, 259-268. doi:10.1016/0740-5472(89)90051-2

*Fu, S. S., Kodl, M., Willenbring, M., Nelson, D. B., Nugent, S., Gravely, A. A., & Joseph, A. M. (2008). Ethnic differences in alcohol treatment outcomes and the effect of concurrent smoking cessation treatment. Drug and Alcohol Dependence, 92, 61-68. doi:10.1016/j.drugalcdep.2007.06.014

*Fuller, R. K., Branchey, L., Brightwell, D. R., Derman, R. M., Emrick, C. D., Iber, F. L.,…Shaw, S. (1986). Disulfram treatment of alcoholism: A Veterans Administration cooperative study. Journal of the American Medical Association, 256, 1449-1455. doi:10.1001/jama.1986.03380110055026

*Gagne, C. A., White, W., & Anthony, W. A. (2007). Recovery: A common vision for the fields of mental health and addictions. Psychiatric Rehabilitation Journal, 31(1), 32-37. doi:10.2975/31.1.2007.32.37

*Gallant, D. M., Faulkner, M., Stoy, B., Bishop, M. P., & Langdon, D. (1968). Enforced clinic treatment of paroled criminal alcoholics: A pilot evaluation. Quarterly Journal of Studies on Alcohol, 29, 77-83.

*Gallanter, M., Dermatis, H., Keller, D., & Manuel, T. (2002). Network therapy for cocaine abuse: Use of family and peer supports. American Journal on Addiction, 11, 161-166. doi:10.1080/10550490290087938
*Gerra, G., Ferri, M., Polidori, E., Santoro, G., Zaimovic, A., & Sternieri, E. (2003). Long-term methadone maintenance effectiveness: Psychosocial and pharmacological variables. Journal of Substance Abuse Treatment, 25, 1-8. doi:10.1016/S0740-5472(03)00031-X
*Gerard, D., Saenger, G., & Wile, R. (1962). The abstinent alcoholic. Archives of General Psychiatry, 6, 83-95.
*Gerstein, D., Judd, L. L., & Rovner, S. A. (1979). Career dynamics of female heroin addicts. American Journal of Drug and Alcohol Abuse, 6, 1-23.
*Gibbins, R. J., & Armstrong, J. D. (1957). Effects of clinical treatment on behavior of alcoholic patients: An exploratory methodological investigation. Quarterly Journal of Studies on Alcohol, 18, 429-450.
*Gibbs, L., & Flanagan, J. (1977). Prognostic indicators of alcoholism treatment outcome. International Journal of the Addictions, 12, 1097-1141.
*Gilder, D. A., Lau, P., Corey, L., & Ehlers, C. L. (2007). Factors associated with remission from cannabis dependence in southwest California Indians. Journal of Addictive Diseases, 26, 23-30. doi:10.1300/J069v26n04_04
*Gillis, L. S., & Keet, M. (1969). Prognostic factors and treatment results in hospitalized alcoholics. Quarterly Journal of Studies on Alcohol, 30, 426-437.
*Gillis, L. S., & Stone, G. L. (1977). The fate of drinkers: A six-year follow-up study of a community survey. South African Medical Journal, 51, 789-791.
*Godley, M. D., Godley, S. H., Dennis, M. L., Funk, 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. doi:10.1016/S0740-5472(02)00230-1
*Godley, S. H., Dennis, M. L, Godley, M. D., & Funk, R. R. (2004). Thirty-month relapse trajectory cluster groups among adolescents discharged from out-patient treatment. Addiction, 99(Suppl. 2), 129-139. doi:10.1111/j.1360-0443.2004.00860.x
*Goldman, E., & Najman, J. (1984). Lifetime abstainers, current abstainers and imbibers: A methodological note. British Journal of Addiction, 79, 309-314. doi:10.1111/j.1360-0443.1984.tb00279.x
*Goldstein, A., & Herrera, J. (1995). Heroin addicts and methadone treatment in Albuquerque: A 22-year follow-up. Drug and Alcohol Dependence, 40(2), 139-150. doi:10.1016/0376-8716(95)01205-2
*Goodwin, D. W., Crane, J. B., & Guze, S. B. (1971). Felons who drink: An eight year follow-up. Quarterly Journal of Studies on Alcohol, 32, 136-147.
*Gordon, A. M. (1983). Drugs and delinquency: A ten year follow-up of drug clinic patients. British Journal of Psychiatry, 142, 169-173. doi:10.1192/bjp.142.2.169
*Gossop, M., Green, L. Phillips, G., & Bradley, B. P. (1989). Lapse, relapse and survival among opiate addicts after treatment: A prospective follow-up study. British Journal of Psychiatry, 154, 348-353. doi:10.1192/bjp.154.3.348

Gossop, M., Marsden, J., Stewart, D., Edwards, C., Lehmann, P, Wilson, A., & Segar, G. (1997). The National Treatment Outcome Research Study in the United Kingdom: Six-month follow-up outcomes. Psychology of Addictive Behaviors, 11(4), 324-337.

*Gossop. M., Marsden, J., Stewart, D., & Kidd, T. (2003). The National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. Addiction, 98, 291-303. doi:10.1046/j.1360-0443.2003.00296.x

*Gossop. M., Marsden, J., Stewart, D., & Rolfe, A. (1999). Treatment retention and 1 year outcomes for residential programmes in England. Drug and Alcohol Dependence, 57, 89-98. doi:10.1016/S0376-8716(99)00086-1

*Gossop. M., Marsden, J., Stewart, D., & Rolfe, A. (2000). Patterns of improvement after methadone treatment: One year follow-up results from the National Treatment Outcome Research Study (NTORS). Drug and Alcohol Dependence, 60, 275-286. doi:10.1016/S0376-8716(00)00109-5

*Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2001). Outcomes after methadone maintenance and methadone reduction treatments: Two-year follow-up results from the National Treatment Outcome Research Study. Drug and Alcohol Dependence, 62(3), 255-264. doi:10.1016/S0376-8716(00)00211-8

*Gossop, M., Marsden, J., Stewart, D., & Treacy, S. (2002). Change and stability of change after treatment of drug misuse: Two year outcomes from the National Treatment Outcome Research Study (UK). Addictive Behaviors, 27, 155-166. doi:10.1016/S0306-4603(00)00174-X

*Gossop, M., Stewart, D., Browne, N., & Marsden, J. (2002). Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: Protective effect of coping responses. Addiction, 97(10), 1259-1267. doi:10.1046/j.1360-0443.2002.00227.x

*Gotham, H. J., Sher, K. J., & Wood, P. K. (1997). Predicting stability and change in frequency of intoxication from the college years to beyond: Individual-difference and role transition variables. Journal of Abnormal Psychology, 106, 619-629.

*Gottheil, E. Thornton, C. C., Skoloda, T. E., & Alterman, A. I. (1982). Follow-up of abstinent and nonabstinent alcoholics. American Journal of Psychiatry, 139, 560-565.

*Graeven, D. B., & Graeven, K. A. (1983). Treated and untreated addicts: Factors associated with participation in treatment and cessation of heroin use. Journal of Drug Issues, 13(2), 207-218.

*Granfield, R., & Cloud, W. (1996). The elephant that no one sees: Natural recovery among middle-class addicts. Journal of Drug Issues, 26(1), 45-61.

*Granfield, R., & Cloud, W. (1999). Coming clean: Overcoming addiction without treatment. New York: New York University Press.

*Grant, B. F. (1996). Toward an alcohol treatment model: A comparison of treated and untreated respondents with DSM-IV alcohol use disorders in the general population. Alcoholism: Clinical and Experimental Research, 20, 372-378. doi:10.1111/j.1530-0277.1996.tb01655.x

Grant, B .F. (1997). Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population sample. Journal of Studies on Alcohol, 58, 365-371.

*Greenfield, S. F., Kolodziej, M. E., Sugarman, D. E., Muenz, L. R., Vagge, L. M., He, D. Y., & Weiss, R. D. (2002). History of abuse and drinking outcomes following inpatient alcohol treatment: A prospective study. Drug and Alcohol Dependence, 67, 227-234. doi:10.1016/S0376-8716(02)00072-8

*Greenfield, S. F., Weiss, R., Muenz, L. Vagge, L., Kelly, J., Bello, L., & Michael, J. (1998). The effect of depression on return to drinking: A prospective study. Archives of General Psychiatry, 55, 259-265.

Grella, C.E., Hser, Y.-I.., & Hsieh, S-C (2003). Predictors of drug treatment re-entry following relapse to cocaine use in DATOS. Journal of Substance Abuse Treatment, 25, 145-154. doi:10.1016/S0740-5472(03)00128-4

*Grella, C. E., Hser, Y.-I., Joshi, V., & Rounds-Bryant, J. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. Journal of Nervous and Mental Disease, 189, 384-392.

Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. American Journal of Drug and Alcohol Abuse, 25(3), 385-406.

*Grella, C. E., Scott, C. K., & Foss, M. A. (2005). Gender differences in long-term drug treatment outcomes in Chicago PETS. Journal of Substance Abuse Treatment, 28, S3-S12. doi:10.1016/j.jsat.2004.08.008

*Grenier, C. (1985). Treatment effectiveness in an adolescent chemical dependency treatment program: A quasi-experimental design. International Journal of the Addictions, 20, 381-391. doi:10.3109/10826088509044920

*Griffin-Shelley, E., Sandler, K. R., & Park-Cameron, R. (1991). A follow-up study of dually diagnosed (chemically dependent) adolescents. Journal of Adolescent Chemical Dependency, 2, 1-11. doi:10.1300/J272v02n01_01

*Gronbaek, M., & Nielsen, B. (2007). A randomized controlled trial of Minnesota day clinic treatment of alcoholics. Addiction, 102, 381-388.

Hamburger, M. E., Leeb, R. T. & Swahn, M. H. (2008). Childhood maltreatment and early alcohol use among high-risk adolescents. Journal of Studies on Alcohol and Drugs, 69, 292-295.

*Harding, W. M., Zinberg, N. E., Stelmack, S. M., & Barry, M. (1980). Formerly-addicted-now-controlled opiate users. International Journal of the Addictions, 15, 47-60.

*Harrington, P., & Cox, T. J. (1979). A twenty-year follow-up of narcotic addicts in Tucson, Arizona. American Journal of Drug and Alcohol Abuse, 6(1), 25-37.

*Harrison, P. A., & Asche, S. (2001). Adolescent treatment for substance use disorders: Outcomes and outcome predictors. Journal of Child & Adolescent Substance Abuse, 11(2), 1-17. doi:10.1300/J029v11n02_01

*Harrison, P. A., & Hoffman, N. G. (1987). CATOR 1987 report. Adolescent residential treatment: Intake and follow-up findings. St. Paul, MN: Chemical Abuse/Addiction Treatment Outcome Registry.

*Hasin, D., Liu, X., Nunes, E., McCloud, S. Samet, S., & Endicott, J. (2002). Effects of major depression on remission and relapse of substance dependence. Archives of General Psychiatry, 59, 375-380.

*Hasin, D., Liu, X., & Paykin, A. (2001). DSM-IV alcohol dependence and sustained reduction in drinking: Investigation in a community sample. Journal of Studies on Alcohol, 62, 509-517.
*Hasin, D. S., & Grant, B. (1995). AA and other help seeking for alcohol problems: Former drinkers in the U.S. general population. Journal of Substance Abuse, 7, 281-292. doi:10.1016/0899-3289(95)90022-5
*Hasin, D. S., Grant, B., & Endicott, J. (1990). The natural history of alcohol abuse: Implications for definitions of alcohol use disorders. American Journal of Psychiatry, 147, 1537-1541.
*Hasin, D. S., Stinson, F. S., Ogburn, E., & Grant, B. F. (2007). Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. Archives of General Psychiatry, 64(7), 830-842.
*Hasin, D. S., Tsai, W.-Y., Endicott, J., Mueller, T. I., Coryell, W., & Keller, M. B. (1996). The effects of major depression on alcoholism: Five-year course. American Journal of Addictions, 5, 144-155.
*Hasin, D. S., Van Rossem, R., McCloud, S., & Endicott, J. (1997). Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. Journal of Substance Abuse, 9, 127-135. doi:10.1016/S0899-3289(97)90011-0
*Havard, A., Teeson, M., Darke, S., & Ross, J. (2006). Depression among heroin users: 12-month outcomes from the Australian Treatment Outcome Study (ATOS). Journal of Substance Abuse Treatment, 30, 355-362. doi:10.1016/j.jsat.2006.03.012
*Haver, B., Dahlgren, L., & Willander, A. (2001). A 2-year follow-up of 120 Swedish female alcoholics treated early in their drinking career: Prediction of drinking outcome. Alcoholism: Clinical and Experimental Research, 25, 1586-1593. doi:10.1111/j.1530-0277.2001.tb02165.x
*Helzer, J. E., Burnam, A., & McEvoy, L. T. (1991). Alcohol abuse and dependence. In L. N. Robins & D. A. Reiger (Eds.), Psychiatric disorders in America: The epidemiologic catchment area study (pp. 81-115). New York: Free Press.
*Helzer, J. E., Robins, L. N., Taylor, J. R., Carey, K., Miller, R. H., Combs-Orme, T., & Farmer, A. (1985). The extent of long-term moderate drinking among alcoholics discharged from medical and psychiatric treatment facilities. New England Journal of Medicine, 312, 1678-1682.
*Henggeler, S. W., Clingempeel, W. G., Brondino, M. J., & Pickrel, S. G. (2002). Four-year follow-up of multisystemic therapy with substance –abusing and substance-dependent juvenile offenders. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 868-874. doi:10.1097/00004583-200207000-00021
*Hermos, J. A., Locastro, J. S., Glynn, R. J., Bouchard, G. R., & De Labry, L. O. (1988). Predictors of reduction and cessation of drinking in community-dwelling men: Results from the normative aging study. Journal of Studies on Alcohol, 49, 363-368.
*Hill, M. J., & Blane, H. T. (1967). Evaluation of psychotherapy with alcoholics: A critical review. Quarterly Journal of Studies on Alcohol, 28, 76-104.
*Hilton, M. (1986). Abstention in the general population of the U.S.A. British Journal of Addiction, 81, 95-112. doi:10.1111/j.1360-0443.1986.tb00300.x

Hingson, R. W., Heeren, T., & Edwards, E. M. (2008). Age at drinking onset, alcohol dependence, and their relation to drug use and dependence, driving under the influence of drugs, and motor-vehicle crash involvement because of drugs. Journal of Studies on Alcohol and Drugs, 69, 192-201.

*Hoff, E. C., & McKeown, C. E. (1953). An evaluation of the use of tetraethylthiuram disulfide in the treatment of 560 cases of alcohol addiction. American Journal of Psychiatry, 109, 670-673.

*Hoffman, J. A., Caudill, B. D., Koman, J. J., III, Luckey, J. W., Flynn, P. M., & Mayo, D. W. (1996). Psychosocial treatments for cocaine abuse: 12-month treatment outcomes. Journal of Substance Abuse Treatment, 13, 3-11. doi:10.1016/0740-5472(95)02020-9

*Hoffman, N. G., & Kaplan, R. A. (1991). CATOR Report: One-year outcome results for adolescents. Key correlates and benefits of recovery. St. Paul, MN: CATOR/New Standards.

*Hoffman, N. G., & Miller, N. S. (1992). Treatment outcomes for abstinence-based programs. Psychiatric Annals, 22, 402-408.

*Howard, C. D., & Hurdum, H. M. (1940). Therapeutic problems in the alcoholic psychoses. Psychiatric Quarterly, 14, 347-359. doi:10.1007/BF01573193

*Hser, Y.-I. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33-year follow-up study. Journal of Addictive Diseases, 26(1), 51-60. doi:10.1300/J069v26n01_07

*Hser, Y.-I., Anglin, M. D., & Powers, K. (1993). A 24-year follow-up of California narcotic addicts. Archives of General Psychiatry, 50, 577-584.

*Hser, Y.-I., Evans, E., & Huang, Y.C. (2005). Treatment outcomes among women and men methamphetamine abusers in California. Journal of Substance Abuse Treatment, 28(1), 77-85. doi:10.1016/j.jsat.2004.10.009

*Hser, Y.-I., Evans, E., Huang, D., Brecht, M. L., & Li, L. (2008). Comparing the dynamic course of heroin, cocaine, and methamphetamine use over 10 years. Addictive Behaviors, 33, 1581-1589. doi:10.1016/j.addbeh.2008.07.024

*Hser, Y.-I., Grella, C. E., Hubbard, R. L., Hsieh, S.-C., Fletcher, B. W., Brown, B. S., & Anglin, M. D. (2001). An evaluation of drug treatments for adolescents in four US cities. Archives of General Psychiatry, 58, 689-695.

*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.

*Hser, Y.-I., Huang, D., Brecht, M-L., Li. L., & Evans, E. (2008). Contrasting trajectories of heroin, cocaine and methamphetamine use. Journal of Addictive Diseases, 27(3), 13-21.

*Hser, Y.-I., Joshi, V., Anglin, M. D., & Fletcher, B. (1999). Predicting posttreatment cocaine abstinence for first-time admissions and treatment repeaters. American Journal of Public Health, 89(5), 666-671.

*Hser, Y.-I., Stark, M. E., Paredes, A., Huang, D., Anglin, M. D., & Rawson, R. (2006). A 12-year follow-up of a treated cocaine-dependent population. Journal of Substance Abuse Treatment, 30, 219-226. doi:10.1016/j.jsat.2005.12.007

*Hsieh, S., Hoffmann, N. G., & Hollister, D. C. (1998). The relationship between pre-, during-, post-treatment factors, and adolescent substance abuse behaviors. Addictive Behaviors, 23, 477-488. doi:10.1016/S0306-4603(98)00028-8
*Hubbard, R. L., Cavanaugh, E. R., Craddock, S. G., & Rachal, J. V. (1985). Characteristics, behaviors and outcomes for youth in the TOPS. In A. A. Friedman & G. M. Beschner (Eds.), Treatment services for adolescent substance abusers (pp. 49-65). Rockville, MD: National Institute on Drug Abuse.
*Hubbard, R. L., Craddock, S. G., & Anderson, J. (2002). Overview of 5-year follow-up outcomes in the Drug Abuse Treatment Outcome Studies (DATOS). Journal of Substance Abuse Treatment, 25, 125-134. doi:10.1016/S0740-5472(03)00130-2
*Hubbard, R. L., & Marsden, M. E. (1986). Relapse to use of heroin, cocaine and other drugs in the first year after treatment. In Relapse and recovery in drug abuse (NIDA Research Monograph 72, pp. 247-253). Rockville, MD U.S. Government Printing Office.
*Humphreys, K., Moos, R. H., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. Journal of Studies on Alcohol, 58(3), 231-238.
*Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two pathways out of drinking problems without professional treatment. Addictive Behaviors, 20(4), 427-441.
*Hunt, G. H., & Odoroff, M. E. (1962). Followup study of narcotic drug addicts after hospitalization. Public Health Reports, 77, 41-54.
*Hunt, W. A., Barnett, L. W., & Branch, L. G. (1971). Relapse rates in addiction programs. Journal of Clinical Psychology, 27, 455-456. doi:10.1002/1097-4679(197110)27:4<455::AID-JCLP2270270412>3.0CO;2-R
*Hunt, W. A., & General, W. R. (1973). Relapse rates after treatment for alcoholism. Journal of Community Psychology, 1, 66-88. doi:10.1002/1520-6629(197301)1:1<66::AID-JCOP2290010119>3.0CO;2-R
*Hyman, H. (1976). Alcoholics 15 years later. Annals of the New York Academy of Sciences, 273, 613-623. doi:10.1111/j.1749-6632.1976.tb52935.x
*Ilgen, M., McKellar, J., & Tiet, Q. (2005). Abstinence self-efficacy and abstinence one year after substance use disorder treatment. Journal of Consulting and Clinical Psychology, 73, 1175-80. doi:10.1037/0022-006X.73.6.1175
*Ilgen, M. A., Wilbourne, P. L., Moos, B. S., & Moos, R. H. (2008). Problem-free drinking over 16 years among individuals with alcohol use disorders. Drug and Alcohol Dependence, 92, 116-122. doi:10.1016/j.drugalcdep.2007.07.006
*Imber, S., Schultz, E., Funderburk, F, Allen, R., & Flamer, R. (1976). The fate of the untreated alcoholic. Toward a natural history of the disorder. The Journal of Nervous and Mental Disorders, 162, 238-247.
*Jackson. K. M., Sher, K. J., Gotham, J. J., & Wood, P. K. (2001). Transitioning into and out of large-effect drinking in young adulthood. Journal of Abnormal Psychology, 110, 378-391. doi:10.1037/0021-843X.110.3.378
*Jacob, T., Koenig, L. B., Howell, D. N., Wood, P. K., & Haber, J. R. (2009). Drinking trajectories from adolescence to the fifties among alcohol-dependent men. Journal of Studies on Alcohol, 70, 859-869.

*Jason, L., Davis, M., & Ferrari, J. (2007). The need for substance abuse aftercare: Longitudinal analysis of Oxford House. Addictive Behaviors, 32, 803-818. doi:10.1016/j.addbeh.2006.06.014
*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.
*Joe, G. W., Chastain, R. L., & Simpson, D. D. (1990). Length of careers. In D. D. Simpson & S. B. Sells (Eds.), Opioid addiction and treatment: A 12-year follow-up. Malabar, FL: Robert E. Krieger Publishing Company.
*Jones, L. E. (1958). How 92% beat the dope habit. Bulletin Los Angeles County Medical Association, 88, 37-40.
*Jorquez, J. (1983). The retirement phase of heroin using careers. Journal of Drug Issues, 13(3), 343-365.
Kadri, A. M., Bhagylaxmi, A., & Kedia, G. (2003). Study of socio-demographic profile of substance users attending a de-addiction centre in Ahmedabad city. Indian Journal of Community Medicine, 28(2), 74-76.
*Kalaydjian, A., Swendsen, J., Chiu, W. T., Dierker, L., Degenhardt, L., Glantz, M.,...Kessler, R. (2009). Sociodemographic predictors of transitions across stages of alcohol use, disorders, and remission in the National Comorbidity Survey Replication. Comprehensive Psychiatry, 50, 299-306. doi:10.1016/j.comppsych.2008.09.012
*Kaminer, Y., & Burleson, J. A. (1999). Psychotherapies for adolescent substance abusers: 15-month follow-up of a pilot study. American Journal on Addictions, 8, 114-119. doi:10.1080/105504999305910
*Kandel, D. B., Johnson, J. G., Bird, H. R., Canino, G., Goodman, S. H., Lahey, B. B.,…Schwab-Stone, M. (1997). Psychiatric disorders associated with substance use among children and adolescents: Findings from the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. Journal of Abnormal Child Psychology, 25, 121-132.
*Kandel, D., & Logan, J. A. (1984). Patterns of drug use from adolescence to young adulthood: I. Periods of risk for initiation, continued use and discontinuation. American Journal of Public Health, 74, 660-666.
*Kandel, D. B., & Raveis, V. H. (1989). Cessation of illicit drug use in young adulthood. Archives of General Psychiatry, 46, 109-116.
*Karno, M. P., Grella, C. E., Niv, N., Warda, U., & Moore, A. A. (2008). Do substance type and diagnosis make a difference? A study of remission from alcohol- versus drug-use disorders using the National Epidemiologic Survey on Alcohol and Related Conditions. Journal of Studies on Alcohol and Drugs, 69, 491-495.
*Kaskutas, L. A., Ammon, L., Delucchi, K., Room, R., Bond, J., & Weisner, C. (2005). Alcoholics Anonymous careers: Patterns of AA involvement five years after treatment entry. Alcoholism: Clinical and Experimental Research, 29(11), 1983-1990. doi:10.1097/01.alc.0000187156.88588.de
*Keller, M., Lavori, P., Beardslee, W., Wunder, J., Drs, D., & Hasin, D. (1992). Clinical course and outcome of substance abuse disorders in adolescents. Journal of Substance Abuse Treatment, 9, 9-14. doi:10.1016/0740-5472(92)90004-8

*Kelly, J. F., Finney, J. F., & Moos, R. (2005). Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. Journal of Substance Abuse Treatment, 28, 213-223. doi:10.1016/j.jsat.2004.10.014
*Kelly, J. F., Myers, M. G., & Brown, S. A. (2000). A multivariate process model of adolescent 12-step attendance and substance use outcome following inpatient treatment. Psychology of Addictive Behaviors, 14, 376-389. doi:10.1037//0893-164X.14.4.376
*Kendell, R. E. (1965). Normal drinking by former alcohol addicts. Quarterly Journal of Studies on Alcohol, 26, 247-257.
*Kendell, R. E., & Staton, M. C. (1966). The fate of untreated alcoholics. Quarterly Journal of Studies on Alcohol, 27(1), 30-41.
*Kennedy, B. P., & Minami, M. (1993). The Beech Hill Hospital/Outward Bound adolescent chemical dependency treatment program. Journal of Substance Abuse Treatment, 10, 395-406. doi:10.1016/0740-5472(93)90025-W
*Kern, J. C., & Schmelter, W. R. (1979). Result of a low cost follow-up study of discharged alcoholics. Alcoholism: Clinical and Experimental Research, 3, 252-254. doi:10.1111/j.1530-0277.1979.tb05309.x
*Keso, L., & Salaspuro, M. (1990). In-patient treatment of employed alcoholics: A randomized clinical trial on Hazelden-type and traditional treatment. Alcoholism: Clinical and Experimental Research, 14, 584-589. doi:10.1111/j.1530-0277.1990.tb01206.x
*Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R. & Walters, E.E. (2005). Lifetime prevalance and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62, 593-603.
*Kessler, R.C., Chiu, W.T., Demier, O. & Walters, E.E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorobity Survey replication. Archives of General Psychiatry, 62, 617-627.
*Kessler, R., McGonagle, K, Zhao, S., Nelson, C., Hughes, M., Eshelman, S.,…Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. Archives of General Psychiatry, 51, 8-19.
King, K. M., & Chassin, L. (2007). A prospective study of the effects of age of initiation of alcohol and drug use on young adult substance dependence. Journal of Studies on Alcohol and Drugs, 68, 256-265.
*Kish, G. B., & Hermann, H. (1971). The Fort Meade alcoholism treatment program: A follow-up study. Quarterly Journal of Studies on Alcohol, 32, 628-635.
*Kissin, B., Rosenblatt, S., & Machover, S. (1968). Prognostic factors in alcoholism. Psychiatric Research Reports, 24, 22-43.
*Knapp, J., Templer, D., Cannon, W. G., & Dobson, S. (1991). Variables associated with success in an adolescent drug treatment program. Adolescence, 26, 305-317.
*Knight, R. G., & Prout, C. T. (1951). A study of results in hospital treatment of drug addictions. American Journal of Psychiatry, 108, 303-308. doi:10.1176/appi.ajp.108.4.303
*Knox, W. J. (1972). Four-year follow-up of veterans treated on a small alcoholism treatment ward. Quarterly Journal of Studies on Alcohol, 33, 105-110.

*Knupfer, G. (1972). Ex-problem drinkers. In M. Roff, L. N. Robins, & M. Pollack (Eds.), Life history research in psychopathology (Vol.2, pp. 256-280). Minneapolis: University of Minnesota Press.
*Knupfer, G., & Room, R. (1970). Abstainers in a metropolitan community. Quarterly Journal of Studies on Alcohol, 31, 108-131.
*Koski-Jännes, A., & Turner, N. (1999). Factors influencing recovery from different addictions. Addiction Research, 7(6), 469-492.
*Kosten, T. A., Gawin, F. H., Kosten, T. R., & Rounsaville, B. J. (1993). Gender differences in cocaine use and treatment response. Journal of Substance Abuse Treatment, 10, 63-66. doi:10.1016/0740-5472(93)90100-G
*Kosten, T. R., Rounsaville, B., & Kleber, H. (1986). A 2.5 year follow-up of depression, life crises, and treatment effects on abstinence among opioid addicts. Archives of General Psychiatry, 43, 733-738.
*Krampe, H., Stawicki, S., Wagner, T., Bartels, C., Aust C., Rüther, E.,…Ehrenreich, H. (2006). Follow-up of 180 alcoholic patients for up to 7 years after outpatient treatment: Impact of alcohol deterrents on outcome. Alcoholism: Clinical and Experimental Research, 30, 86-95. doi:10.1111/j.1530-0277.2006.00013.x
*Kranzler, H. R., Del Boca, F. K., & Rounsaville, B. J. (1996). Comorbid psychiatric diagnosis predicts three-year outcomes in alcoholics: A posttreatment natural history study. Journal of Studies on Alcohol, 5, 619-626.
*Kurland, A. A. (1968). Maryland alcoholics: Follow-up study I. Psychiatric Research Reports, 24, 71-82.
*Langenauer, B. J., & Bowden, C. L. (1971). A follow-up study of narcotic addicts in the NARA Program. American Journal of Psychiatry, 128, 41-46. doi:10.1176/appi.ajp.128.1.41
*Larm, P., Hodgins, S, Larsson, A., Samuelson, Y. M., & Tengstrom, A. (2008). Long-term outcomes of adolescents treated for substance misuse. Drug and Alcohol Dependence, 96, 79-89. doi:10.1016/j.drugalcdep.2008.01.026
*Latimer, W. W., Newcomb, M., Winters, K. C., & Stinchfield, R. D. (2000). Adolescent substance abuse treatment outcome: The role of substance abuse problem severity, psychosocial, and treatment factors. Journal of Consulting and Clinical Psychology, 68(4), 684-696. doi:10.1037/0022-006X.68.4.684
*Laudet, A., Stanick, V., & Sands, B. (2007). An exploration of the effect of on-site 12-step meetings on post-treatment outcomes among polysubstance-dependent outpatient clients. Evaluation Review, 31(6), 613-646. doi:10.1177/0193841X07306745
*Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. Journal of Substance Abuse Treatment, 33, 243-256. doi:10.1016/j.jsat.2007.04.014
*Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. Substance Use and Misuse, 43(1), 27-54. doi;10.1080/10826080701681473
Leichtling, G., Gabriel, R. M., Lewis, C. K., & Vander Ley, K .J. (2006). Adolescents in treatment: Effects of parental substance abuse on treatment entry characteristics and outcomes. Journal of Social Work Practice in the Addictions, 6(1/2), 155-174. doi:10.1300/J160v06n01_08

*Lemere, F. (1953). What happens to alcoholics? American Journal of Psychiatry, 109, 674-676. doi:10.1176/appi.ajp.109.9.674
*Lemere, F., & O'Hallaren, P. (1950). Thiopental U.S.P. ("Pentothal") treatment of alcoholism. Archives of Neurological Psychiatry, 63, 579-585.
*Lemere, F., & Voegtlin, W. L. (1940). Conditioned reflex therapy of alcoholic addiction: Specificity of conditioning against chronic alcoholism. California and Western Medicine, 53(6), 268-269.
*Lemere, F., & Voegtlin, W. (1950). An evaluation of the aversion treatment of alcoholism. Quarterly Journal of Studies on Alcohol, 11, 199-204.
*Lerner, A. G., Gelkopf, M., Sigal, M., & Oyffe, I. (1997). Indicators of good prognosis in naltrexone treatemnt: A five-year prospective study. Addiction Research, 4(4), 385-391.
*Leung, P. K., Kinzie, J. D., Boehnlein, J. K., & Shore, J. H. (1993). A prospective study of the natural course of alcoholism in a Native American village. Journal of Studies on Alcohol, 54, 733-738.
*Levy, B. S. (1972). Five years after: A follow-up of 50 narcotic addicts. American Journal of Psychiatry, 128(7), 868-872. doi:10.1176/appi.ajp.128.7.868
Lloyd, D. A., & Turner, R. J. (2008). Cumulative lifetime adversities and alcohol dependence in adolescence and young adulthood. Drug and Alcohol Dependence, 93, 217-226. doi:10.1016/j.drugalcdep.2007.09.012
*Longabaugh, R., Mattson, M. E., Connors, G. J., & Cooney, N. L. (1994). Quality of life as an outcome variable in alcoholism treatment research. Journal of Studies on Alcohol Supplement, 12, 119-129.
*Loosen, P. T., Dew, B. W., & Prange, A. J. (1990). Long-term predictors of outcome in abstinent alcoholic men. American Journal of Psychiatry, 147, 1662-1666.
*Lopez-Quintero, C., Hason, D. J., de los Cobas, J. P., Pines, A., Wang, S., Grant, B. F., & Blanco, C. (2010). Probability and predictors of remission from life-time nicotine, alcohol, cannabis or cocaine dependence: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Addiction, 106(3), 657-669. doi:10.1111/j.1360-0443.2010.03194.x
Lovibond, S. H., & Caddy, G. R. (1970). Discriminated aversive control in the moderation of alcoholics' drinking behavior. Behavior Therapy, 1, 437-444. doi:10.1016/S0005-7894(70)80069-7
*Lowman, C., Allen, J., & Miller, W. R. (1996). Perspectives on precipitants of relapse. Addiction, 91(Supplement), S3-S4. doi:10.1080/09652149638755
*Lozano, B. E., Stephens, R. S., & Roffman, R. A. (2006). Abstinence and moderate use goals in the treatment of marijuana dependence. Addiction, 101, 1589-1597. doi:10.1111/j.1360-0443.2006.01609.x
*Mackenzie, A., Allen, R. P., & Funderburk, F. R. (1986). Mortality and illness in male alcoholics: An 8-year follow-up. International Journal of the Addictions, 21, 865-882.
*Maddux, J. F., & Desmond, D. P. (1981). Careers of opioid users. New York: Praeger.
*Maddux, J. F., & Desmond, D. P. (1986). Relapse and recovery in substance abuse careers. In F. Tims, & C. Leukefeld (Eds.), Relapse and recovery in drug abuse (NIDA Monograph 72, pp. 49-72). Rockville, MD: National Institute on Drug Abuse.

*Maddux, J. F., & Desmond, D. P. (1992). Ten-year follow-up after admission to methadone maintenance. American Journal of Drug and Alcohol Abuse, 18(3), 289-303.
*Maisto, S. A., Clifford, P. R., Stout, R. L., & Davis, C. M. (2006). Drinking in the year after treatment as a predictor of three-year drinking outcomes. Journal of Studies on Alcohol, 67, 823-832.
*Maisto, S. A., Martin, C. S., Pollock, N. K., Cornelius, J. R., & Chung, T. (2002). Non-problem drinking outcomes in adolescents treated for alcohol use disorders. Experimental and Clinical Psychopharmacology, 10, 324-331.
*Maisto, S. A., Pollock, N. K., Lynch, K. G., Martin, C. S., & Ammerman, R. (2001). Course of functioning in adolescents 1 year after alcohol and other drug treatment. Psychology of Addictive Behaviors, 15(1), 68-76. doi:10.1037//0893-164X.15.1.68
*Mann, K., Schafer, D. R., Langle, G., Ackerman, K., & Croissant, B. (2005). The long-term course of alcoholism, 5. 10 and 16 years after treatment. Addiction, 100, 797-805. doi:10.1111/j.1360-0443.2005.01065.x
*Marinelli-Casey, P., Gonzales, R., Hillhouse, M., Ang, A., Zweben, J., Cohen, J.,…Methamphetamine Treatment Project Corporate Authors. (2008). Drug court treatment for methamphetamine dependence: Treatment response of post-treatment outcomes. Journal of Substance Abuse Treatment, 34, 242-248. doi:10.1016/j.jsat.2007.04.005
*Marzen, T. J. (1990). The effectiveness of an adolescent rehabilitation program for alcohol and other drug addictions in a San Francisco hospital: A 5 year follow-up study. Dissertations Abstracts International, 51, 2979-A.
*McAweeney, M. J., Zucker, R. A., Fitzgerald, H. E., Puttler, L. I., & Wong, M. M. (2005). Individual and partner predictors of recovery from alcohol use disorder over a nine-year interval: Findings from a community sample of alcoholic married men. Journal of Studies on Alcohol, 66(2), 220-228.
*McCabe, R. J. R. (1986). Alcohol-dependent individuals sixteen years on. Alcohol and Alcoholism, 21, 85-91.
*McCartney, J. (1996). A community study of natural change across the addictions. Addiction Research, 4, 65-83.
*McGlothlin, W. H., Anglin, M. D., & Wilson. B. D. (1977). A follow-up of admissions to the California Civil Addict Program. American Journal of Alcohol and Drug Abuse, 4(2), 179-199.
*McIntosh, J., & McKeganey, N. (2002). Beating the dragon: The recovery from dependent drug use. Prentice Hall: Harlow, England.
*McKay, J. R (2009). Treating substance use disorders with adaptive continuing care.
Washington, D.C.: American Psychological Association.
*McKay, J. R., & Weiss, R. V. (2001). A review of temporal effects and outcomes predictors in substance abuse treatment studies with long-term follow-ups: Preliminary results and methodological issues. Evaluation Review, 25, 113-161. doi:10.1177/0193841X0102500202
*McLellan, A. T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. Journal of Substance Abuse Treatment, 38, 200-201. doi:10.1016/j.jsat.2009.11.002

*McLellan, A. T., Alterman, A. I., Metzger, D. S., Grissom, G. R., Woody, G. E., Luborsky, L., & O'Brien, C. P. (1994). Similarity of outcome predictors across opiate, cocaine, and alcohol treatments: Role of treatment services. Journal of Consulting and Clinical Psychology, 62(6), 1141-1158. doi:10.1037/0022-006X.62.6.1141

*McLellan, A. T., Grissom, G. R., Brill, P., Durell, J., Metzger, D. S., & O'Brien, C. P. (1993). Private substance abuse treatments: Are some programs more effective than others? Journal of Substance Abuse Treatment, 10, 243-254. doi:10.1016/0740-5472(93)90071-9

*McLellan, A. T., Skipper, G. S., Campbell, M., & DuPont, R. L. (2008). Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. British Medical Journal, 337a2038. doi:10.1136/bmj.a2038

*McPeake, J. D., Kennedy, B., Grossman, J., & Beaulieu, L. (1991). Innovative adolescent chemical dependency treatment and its outcome: A model based on Outward Bound programming. Journal of Adolescent Chemical Dependency, 2, 29-57. doi:10.1300/J272v02n01_03

*McRae, A. L., Budney, A. J., & Brady, K. T. (2003). Treatment of marijuana dependence: A review of the literature. Journal of Substance Abuse Treatment, 24, 369-376. doi:10.1016/S0740-5472(03)00041-2

*Miller, M. M. (1959). Treatment of chronic alcoholism with hypnotic suggestion. Journal of the American Medical Association, 171, 1492-1495.

*Miller, N. S., & Hoffman, N. G. (1995). Addictions treatment outcomes. Alcoholism Treatment Quarterly, 12, 41-55. doi:10.1300/J020v12n02_03

*Miller, W. R. (1978). Behavioral treatment of problem drinkers: A comparative outcome study of three controlled drinking therapies. Journal of Consulting and Clinical Psychology, 46, 74-86. doi:10.1037/0022-006X.46.1.74

*Miller, W. R. (1983). Controlled drinking: A history and a critical review. Journal of Studies on Alcohol, 44, 68-83.

*Miller, W. R., & Baca, L. M. (1983). Two-year follow-up of bibliotherapy and therapist-directed controlled drinking training for problem drinkers. Behavior Therapy, 14, 441-448. doi:10.1016/S0005-7894(83)80107-5

*Miller, W. R., & Caddy, R. (1977). Abstinence and controlled drinking in the treatment of problem drinkers. Journal of Studies on Alcohol, 38(5), 986-1003.

Miller, W. R., & Hester, R. K. (1980). Treating the problems drinkers: Modern approaches. In W. R. Miller (Ed.), The addictive behaviors: Treatment of alcoholism, drug abuse, smoking and obesity (pp. 11-141). Elmsford, NY: Pergamon Press, Inc.

*Miller, W. R., & Joyce, M. A. (1979). Prediction of abstinence, controlled drinking, and heavy drinking outcomes following behavioral self-control training. Journal of Consulting and Clinical Psychology, 47, 773-775. doi:10.1037/0022-006X.47.4.773

*Miller, W. R., Leckman, A. L., Delaney, H. D., & Tinkcom, M. (1992). Long-term follow-up of behavioral self-control training. Journal of Studies on Alcohol, 53, 249-261.

*Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? Journal of Studies on Alcohol, 62(2), 211-220.

*Mindlin, D. F. (1959). The characteristics of alcoholics as related to the prediction of therapeutic outcome. Quarterly Journal of Studies on Alcohol, 20, 604-619.

*Misch, D. A. (2007). "Natural recovery" from alcohol abuse among college students. Journal of American College Health, 55(4), 215-218.
*Monahan, S. C., & Finney, J. W. (1996). Explaining abstinence rates following treatment for alcohol abuse: A quantitative synthesis of patient, research design and treatment effects. Addiction, 91, 787-805. doi:10.1046/j.1360-0443.1996.9167876.x
*Moore, B. A., & Budney, A. J. (2003). Relapse in outpatient treatment for marijuana dependence. Journal of Substance Abuse Treatment, 25, 85-89. doi:10.1016/S0740-5472(03)00083-7
*Moore, R. A, & Buchanan, T. K. (1966). State hospitals and alcoholism: A nation-wide survey of treatment techniques and results. Quarterly Journal of Studies on Alcohol, 27, 459-468.
*Moore, R. A., & Ramseur, F. (1966). A study of the background of 100 hospitalized veterans with alcoholism. Quarterly Journal of Studies on Alcohol, 21, 51-67.
Moos, H. B., Chen, C. M., & Yi, H.-Y. (2007). Subtypes of alcohol dependence in a nationally representative sample. Drug and Alcohol Dependence, 91, 149-158. doi:10.1016/j.drugalcdep.2007.05.016
*Moos, R. H. (1994). Why do some people recover from alcohol dependence, whereas others continue to drink and become worse over time? Addiction, 89, 31-34. doi:10.1111/j.1360-0443.1994.tb00846.x
*Moos, R. H. (1994). Treated or untreated, an addiction is not an island unto itself. Addiction, 89, 507-509. doi:10.1111/j.1360-0443.1994.tb03315.x
*Moos, R. H., Brennan, P. L., & Moos, B. S. (1991). Short-term processes of remission and nonremission among late-life problem drinkers. Alcoholism: Clinical and Experimental Research, 15, 948-955.
*Moos. R. H., & Finney, J. W. (2011). Commentary on Lopez-Quintero et al. (2011). Remission and relapse—the Yin-Yang of addictive disorders. Addiction, 106, 670-671. doi:10.1111/j.1360-0443.2010.00003284.x
*Moos. R. H., Finney, J. W., & Cronkite, R. C. (1990). Alcoholism treatment: Context, process and outcome. New York: Oxford University Press.
*Moos, R. H., Finney, J. W., Federman, E. B., & Suchinsky, R. (2000). Specialty mental health care improves patients' outcomes: Findings from a nationwide program to monitor the quality of care for patients with substance use disorders. Journal of Studies on Alcohol, 61, 704-713.
*Moos, R. H., & Moos, B. S. (2005b). Sixteen-year changes and stable remission among treated and untreated individuals with alcohol use disorders. Drug and Alcohol Dependence, 80(3), 337-347. doi:10.1016/j.drugalcdep.2005.05.001
*Moos, R. H., & Moos, B. S. (2006a). Rates and predictors of relapse after natural and treated remission from alcohol use disorders. Addiction, 101, 212-222. doi:10.1111/j.1360-0443.2006.01310.x
*Moos, R. H., & Moos, B. S. (2006b). Participation in treatment and Alcoholics Anonymous: A 16-year follow-up of initially untreated individuals. Journal of Clinical Psychology, 62(6), 735-750. doi:10.1002/jclp.20259

*Moos, R. H., & Moos, B. S. (2007). Treated and untreated alcohol-use disorders: Course and predictors of remission and relapse. Evaluation Review, 31, 564-584. doi:10.1177/0193841X07306749
*Moyer, A., & Finney, J. W. (2002). Outcomes for untreated individuals involved in randomized trials of alcohol treatment. Journal of Substance Abuse Treatment, 23(2), 247-252. doi:10.1016/S0740-5472(02)00264-7
*Muga, R., Tor, J., Ginesta, C., Melus, R., Jacas, C., Rev-Joly, C. & Foz, M. (1990). Natural history of parenteral drug addicts treated in a general hospital. British Journal of Addiction, 85, 775-778. doi:10.1111/j.1360-0443.1990.tb01690.x
*Mullen, K., & Hammersley, R. H. (2006). Attempted cessation of heroin use among men approaching mid-life. Drug-Education, Prevention Policy, 13, 77-92. doi:10.1080/09687630500343137
*Murphy, S., Reinarman, C., & Waldorf, D. (1989). An 11-year follow-up of a network of cocaine users. British Journal of Addiction, 84, 427-436. doi:10.1111/j.1360-0443.1989.tb00586.x
*Muthén, B. O., & Muthén, L. K. (2000). The development of heavy drinking and alcohol-related problems from ages 18 to 37 in a US national sample. Journal of Studies on Alcohol, 61, 290-300.
*Myers, M. G., Brown, S. A., & Mott, M. A. (1995). Preadolescent conduct disorder behaviors predict relapse and progression of addiction for adolescent alcohol and drug abusers. Alcoholism: Clinical and Experimental Research, 19, 1528-1536. doi:10.1111/j.1530-0277.1995.tb01019.x
*Myerson. D. J., & Mayer J. (1966). Origins, treatment and destiny of skid row alcoholic men. New England Journal of Medicine, 275, 419-425.
Nathan, P. E., & Skinstad, A.-H. (1987). Outcomes of treatment for alcohol problems: Current methods, problems and results. Journal of Consulting and Clinical Psychology, 55, 332-340.
*Newcomb, M. D., Galaif, E. R., & Locke, T. F. (2001). Substance use diagnosis within a community sample of adults: Distinction, comorbidity, and progression over time. Professional Psychology: Research and Practice, 32, 239-247.
* Nielsen, B., & Norvig, J. (1956). A follow-up study of 221 alcohol addicts in Denmark. Quarterly Journal of Studies on Alcohol, 17, 633-642.
*Nordstrom, G., & Berglund, M. (1986). Successfully adjusted alcoholics lost to long-term follow-up. A prospective study. Drug and Alcohol Dependence, 18, 11-22. doi:10.1016/0376-8716(86)90110-9
*Nordstrom, G., & Berglund, M. (1987a). Ageing and recovery from alcoholism. British Journal of Psychiatry, 151, 382-388. doi:10.1192/bjp.151.3.382
*Nordstrom, G., & Berglund, M. (1987b). A prospective study of successful long-term adjustment in alcohol dependence: Social drinking versus abstinence. Journal of Studies on Alcohol, 48, 95-103.
Norman, S .B., Tate, S. R., Anderson, K. G., & Brown, S. A. (2007). Do trauma history and PTSD symptoms influence addiction relapse context? Drug and Alcohol Dependence, 90, 89-96. doi:10.1016/j.drugalcdep.2007.03.002

*Nurco, D. N., Cisin, I., & Baiter, M. B. (1981). Addict careers, III: Trends across time. International Journal of the Addictions, 16, 1357-1372.
*O'Connor, A., & Daly, J. (1985). Alcoholics: A twenty-year follow-up study. British Journal of Psychiatry, 146, 645-647. doi:10.1192/bjp.146.6.645
*O'Donnell, J. A. (1964). A follow-up of narcotic addicts: Mortality, relapse and abstinence. American Journal of Orthopsychiatry, 34, 948-954. doi:10.1111/j.1939-0025.1964.tb02251.x
*O'Donnell, J. A. (1969). Narcotic addicts in Kentucky (Public Health Service Publication No. 1881). Washington D.C.: Superintendent of Documents, US Govt. Printing Office.
*Office of Communications (2008). Summary Report CARAVAN Survey for SAMHSA on Addictions and Recovery. Rockville, MD: Substance Abuse and Mental Health Services Administration.
*Ogborne, A. C., & Melotte, C. (1977). An evaluation of a therapeutic community for former drug users. British Journal of Addiction, 72, 75-82. doi:10.1111/j.1360-0443.1977.tb03968.x
*Ojesjo, L. (1981). Long-term outcome in alcohol abuse and alcoholism among males in the Lundby general population, Sweden. British Journal of Addiction, 76, 391-400. doi:10.1111/j.1360-0443.1981.tb03237.x
*Ojesjo, L. (2000). The recovery from alcohol problems over the life course: The Lundby longitudinal study, Sweden. Alcohol, 22, 1-5. doi:10.1016/S0741-8329(00)00106-3
*Ojesjo, L., Hagnell, O., & Otterbeck, L. (2000). The course of alcoholism among men in the Lundby Longitudinal Study, Sweden. Journal of Studies on Alcohol, 61, 320-322.
*Okruhlica, L., Mihalkova, A., Klempova, D., & Skovayova, L. (2002). Three-year follow-up study of heroin users in Bratislava. European Addiction Research, 8(2), 103-106. doi:10.1159/000052061
*Orford, J., Oppenheimer, E., & Edwards, G. (1976). Abstinence or control: The outcome for excessive drinkers two years after consultation. Behaviour Research and Therapy, 14, 409-418. doi:10.1016/0005-7967(76)90087-5
*O'Sullivan, K., Rynne, C., Miller, J., O'Sullivan, S., Fitzpatrick, V., Hux, M.,…Clare, A. (1988). A follow-up study on alcoholics with and without co-existing affective disorder. British Journal of Psychiatry, 152, 813-819. doi:10.1192/bjp.152.6.813
*Ouimette, P., Moos, R. H., & Finney, J. W. (2003). PTSD treatment and 5-year remission among patients with substance use and posttraumatic stress disorders. Journal of Consulting and Clinical Psychology, 71(2), 410-414. doi:10.1037/0022-006X.71.2.410
*Ouimette, P. C., Finney, J. W., & Moos, R. H. (1997). Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. Journal of Consulting and Clinical Psychology, 65, 230-240.
*Paille, F. M., Guelfi, J. D., Perkins, A. C., Royer, R. J., Steru, L., & Parot, P. (1995). Double-blind randomized multicentre trial of acamprosate in maintaining abstinence from alcohol. Alcohol and Alcoholism, 30, 239-247.
*Paredes, A., Gregory, D., Rundell, O. H., & Williams, H. L. (1979). Drinking behavior, remission, and relapse: The Rand Report revisited. Alcoholism: Clinical and Experimental Research, 3(1), 3-10. doi:10.1111/j.1530-0277.1979.tb04758.x

*Patterson, D. G., Macpherson, J., & Brady, N. A. (1997). Community psychiatric nurse aftercare for alcoholics: A five-year follow-up study. Addiction, 92, 459-468. doi:10.1111/j.1360-0443.1997.tb03377.x
*Pattison, E. M., Coe, R., & Rhodes, R. J. (1969). Evaluation of alcoholism treatment. A comparison of three facilities. Archives of General Psychiatry, 20, 478-488.
*Pattison, E. M., Headley, E. B., Gleser, G. C., & Gottschalk, L. A. (1968). Abstinence and normal drinking: An assessment of changes in drinking patterns in alcoholics after treatment. Quarterly Journal of Studies on Alcohol, 29, 610-633.
*Patton, G. C., Coffey, C., Lynskey, M. T., Reid, S., Hemphill, S., Carlin, J. B., & Hall, W. (2007). Trajectories of adolescent alcohol and cannabis use into young adulthood. Addiction, 102, 607-615. doi:10.1111/j.1360-0443.2006.01728.x
*Pemberton, D. A. (1967). A comparison of the outcome of treatment in female and male alcoholics. British Journal of Psychiatry, 113, 367-373. doi:10.1192/bjp.113.497.36
*Prendergast, M. L., Podus, D., Chang, E., & Urada, D. (2002). The effectiveness of drug abuse treatment: A meta-analysis of comparison group studies. Drug and Alcohol Dependence, 67, 53-72. doi:10.1016/S0376-8716(02)00014-5
*Pendery, M. L., Maltzman, I. M., & West, L. J. (1982). Controlled drinking by alcoholics? New findings and a reevaluation of a major affirmative study. Science, 217, 169-175. doi:10.1126/science.7089552
*Penick, E. C., Knop, J., Nickel, E. J., Jensen, P., Manzardo, A. M., Lykke-Mortensen, E., & Gabrielli, W. F. (2010). Do premorbid predictors of alcohol dependence also predict the failure to recover from alcoholism? Journal of Studies on Alcohol, 71, 685-694.
*Perkonigg, A., Goodwin, R .D., Fiedler, A., Behrendt, S., Beesdo, K., Lieb, R., & Wittchen, H.-U. (2008). The natural course of cannabis use, abuse, and dependence during the first decades of life. Addiction, 103(3), 439-449. doi:10.1111/j.1360-0443.2007.02064.x
*Perkonigg, A., Lieb, R., Hofler, M., Schuster, P., Sonntag, H., & Wittchen, H.-U. (1999). Patterns of cannabis use, abuse and dependence over time: Incidence, progressions and stability in a sample of 1228 adolescents. Addiction, 94, 1663-1678. doi:10.1046/j.1360-0443.1999.941116635.x
*Perreira, K. M., & Sloan, F. A. (2002). Excess alcohol consumption and health outcomes: A 6-year follow-up of men over age 50 from the health and retirement study. Addiction, 97, 301-310. doi:10.1046/j.1360-0443.2002.00067.x
*Pescor, M. J. (1943). Follow-up study of treated narcotic drug addicts. Sup. No. 170 to the Public Health Reports. U.S. Government Printing Office, Washington, D.C.
*Peter D. Hart Associates (2001). The Face of Recovery, October 2001. Washington DC: Faces and Voices of Recovery.
*Pettinati, H. M., Sugerman, A. A., DiDonato, N., & Maurer, H. S. (1982). The natural history of alcoholism over four years after treatment. Journal of Studies on Alcohol, 43, 201-215.
*Pfeffer, A. Z., & Berger, S. (1957). A follow-up study of treated alcoholics. Quarterly Journal of Studies on Alcohol, 18, 624-648.
*Pokorny, A., Miller, B., & Cleveland, S. (1968). Response to treatment of alcoholism: A follow-up study. Quarterly Journal of Studies on Alcohol, 29, 364-381.

*Polcin, D. L., Korcha, R. A., Bond, J., & Galloway, G. (2010). Sober living houses for alcohol and drug dependence: 18-month outcomes. Journal of Substance Abuse Treatment, 38, 356-365. doi:10.1016/j.jsat.2010.02.003
*Polich, J. M., Armor, D. J., & Braiker, H. B. (1980). The course of alcoholism: Four years after treatment. New York: Wiley.
*Powell, B. J., Penick, E. C., Nickel, E.J., Liskow, B. I., Riesenmy, K. D., Campion, S. L., & Brown, E. F. (1992). Outcomes of co-morbid alcoholic men: A 1-year follow-up. Alcoholism: Clinical and Experimental Research, 16, 131-138. doi:10.1111/j.1530-0277.1992.tb00649.x
*Price, R. K., Risk, N. K., & Spitznagel, E. L. (2001). Remission from drug abuse over a 25 year period: Patterns of remission and treatment use. American Journal of Public Health, 91, 1107-1113.
*Proceedings 1870-1875, American Association for the Cure of Inebriates. (1981). New York: Arno Press
*Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Journal of Studies on Alcohol, 58, 7-29.
*Project Match Research Group (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism: Clinical and Experimental Research, 22, 1300-1311. doi:10.1111/j.1530-0277.1998.tb03912.x
*Prout, C. T., Strongin, E. I., & White, M. A. (1950). A study of results in hospital treatment of alcoholism in males. American Journal of Psychiatry, 107, 14-19. doi:10.1176/appi.ajp.107.1.14
*Query, J. M. N. (1985). Comparative admission and follow-up study of American Indians and Whites in a youth chemical dependency unit on the north central plains. The International Journal of the Addictions, 20, 489-502. doi:10.3109/10826088509044928
*Quintero, G. (2000) “The lizard in the green bottle”: “Aging out” of problem drinking among Navajo men. Social Science and Medicine, 51, 1031-1045. doi:10.1016/S0277-9536(00)00017-4
*Ralph, R., & Corrigan, P. (Eds.) (2004). Recovery and mental illness: Consumer visions and research paradigms. Washington DC: American Psychological Association.
*Rathod, N. H., Addenbrooke, W., & Rosenbach, A. F. (2005). Heroin dependence in an English town: 33-year follow-up. British Journal of Psychiatry, 187(5), 421-425. doi:10.1192/bjp.187.5.421
*Rathod, N. H., Gregory, E., Blows, D., & Thomas, G. H. (1966). A two-year follow-up study of alcoholic patients. British Journal of Psychiatry, 112, 683-692. doi:10.1192/bjp.112.488.68
*Rawson, R. A., Huber, A., Brethen, M. A., Obert, J., Gulati, V., Shoptaw, S., & Ling, W. (2001). Status of methamphetamine users 2-5 years after outpatient treatment. Journal of Addictive Diseases, 21(1), 107-119. doi:10.1300/J069v21n01_09
*Rawson, R. A., Marinelli-Casey, P., Anglin, M. D., Dickow, A., Frazier, Y., Gallagher, C.,…Methamphetamine Treatment Project Corporate Authors. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. Addiction, 99, 708-717. doi:10.1111/j.1360-0443.2004.00707.x

*Ray, G. T., Weisner, C. M., & Mertens, J. R. (2005). Relationship between use of psychiatric services and five-year alcohol and drug treatment outcomes. Psychiatric Services, 56(2), 164-171.
*Ray, M. (1961). The cycle of abstinence and relapse among heroin addicts. Social Problems, 9, 132-140.
*Ray, M. B. (1968). Abstinence cycles and heroin addicts. In E. Rubington & M. Weinberg (Eds.), Deviance: The interactitionist perspective (pp. 484-492). London: Macmillan.
Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Archives of General Psychiatry, 50, 85-94.
*Reinert, R. E., & Bowen, W. T. (1968). Social drinking following treatment for alcoholism. Bulletin of the Menninger Clinic, 32, 280-290.
Raimo, E. B., Daeppen, J. B., Smith, T. L., Danko, G. P., & Schuckit, M. A. (1999). Clinical characteristics of alcoholism in alcohol-dependent subjects with and without a history of alcohol treatment. Alcoholism: Clinical and Experimental Research, 23, 1605-1613. doi:10.1111/j.1530-0277.1999.tb04050.x
*Ribeiro, M., Dunn, J., Sesso, R., Lima, M., & Laranjeira, R. (2007). Crack cocaine: A five-year follow-up study of treated patients. European Addiction Research, 13(1), 11-19. doi:10.1159/000095810
*Richardson, D. W. (1996). Drug rehabilitation in a treatment farm setting: The Nitawgi experience, 1978-1990. Journal of Development & Behavioral Pediatrics, 17, 258-261.
*Richter, S., Brown, S., & Mott, M. (1991). The impact of social support and self-esteem on adolescent substance abuse treatment outcome. Journal of Substance Abuse, 3, 371-385. doi:10.1016/S0899-3289(10)80019-7
*Ritsher, J. B., McKellar, J. D., Finney, J. W., Otilingam, P. G., & Moos, R. H. (2002a). Psychiatric comorbidity, continuing care and mutual help as predictors of five-year remission from substance use disorders. Journal of Studies on Alcohol, 63, 709-715.
*Ritsher, J. B., Moos, R. H., & Finney, J. W. (2002). Relationship of treatment orientation and continuing care to remission among substance abuse patients. Psychiatric Services, 53(5), 595-601.
*Ritson, B. (1968). The prognosis of alcohol addicts treated by a specialized unit. British Journal of Psychiatry, 114, 1019-1029. doi:10.1192/bjp.114.513.1019
*Rivers, S. M., Greenbaum, R. L., & Goldberg, E. (2001). Hospital-based adolescent substance abuse treatment: Comorbidity, outcomes and gender. Journal of Nervous and Mental Disease, 189(4), 229-237.
*Robins, L. N. (1993). Vietnam veterans' rapid recovery from heroin addiction: A fluke or normal expectation? Addiction, 88, 1041-1054. doi:10.1111/j.1360-0443.1993.tb02123.x
*Robins, L. N., Davis, D. D., & Nurco, D. N. (1974). How permanent was Vietnam drug addiction? American Journal of Public Health, 64(12 Suppl), 38-43.
*Robins, L. N., Helzer, J. E., & Davis, D. H. (1975). Narcotic use in Southeast Asia and afterward: An interview study of 898 Vietnam returnees. Archives of General Psychiatry, 32, 955-961.

*Robins, L. N., Locke, B. Z., & Regier, D. (1991). An overview of psychiatric disorders in America. In L. N. Robins & D. A. Regier (Eds.), Psychiatric disorders in America: The Epidemiologic Catchment Area Study (pp. 328-366). New York: The Free Press.
Robins, L. N., & Murphy, G. E. (1967). Drug use in a normal population of young Negro men. American Journal of Public Health, 57, 1580-1596.
*Robinson, E. R., Krentzman, A. R., Webb, J. R., & Brower, K. J. (2011). Six-month changes in spirituality and religiousness in alcoholics predict drinking outcomes at nine months. Journal of Studies on Alcohol and Drugs, 72, 660-668.
*Robson, R. A. H., Paulus, I., & Clarke, G. G. (1965). An evaluation of the effect of a clinic treatment program on the rehabilitation of alcoholic patients. Quarterly Journal of Studies on Alcohol, 26, 264-278.
*Rohan, W. P. (1970). A follow-up study of hospitalized problem drinkers. Disease of the Nervous System, 31, 259-264.
*Roizen, R., Cahalan, D., & Shanks, P. (1978). "Spontaneous remission" among untreated problem drinkers. In D. B. Kandel (Ed.), Longitudinal rResearch on drug use, empirical findings and the methodological issues (pp. 197-221). New York: John Wiley & Sons.
*Room, R. (1968, September). Amount of drinking and alcoholism. Paper prepared for the 28th International Congress on Alcohol and Alcoholism, Washington, DC.
*Room, R. (1989). The U.S. general population's experiences of responding to alcohol problems. British Journal of Addiction, 84, 1291-1304. doi:10.1111/j.1360-0443.1989.tb00731.x
*Room, R., & Greenfield, T. (1993). Alcoholics Anonymous, other 12-step movements and psychotherapy in the US population, 1990. Addiction, 88, 555-562. doi:10.1111/j.1360-0443.1993.tb02062.x
Ross, H. E., Lin, E., & Cunningham, J. (1999). Mental health service use: A comparison of treated and untreated individuals with substance use disorders in Ontario. Canadian Journal of Psychiatry, 44(6), 570-577.
*Rossi, J. J., Stack, A., & Bradley, J. (1963). Effects of treatment of male alcoholics in a mental hospital. Quarterly Journal of Studies on Alcohol, 24, 91-108.
*Rumpf, H.-J., Bischof, G., Hapke, U., Meyer, C., & John, U. (2006). Stability of remission from alcohol dependence without formal help. Alcohol and Alcoholism, 41(3), 311-314. doi:10.1093/alcalc/agl008
*Russell, M., Peirce, R. S., Chan, A. W. K., Wieczorek, W. F., Moscato, B. S., & Nochajski, T. H. (2001). Natural recovery in a community-based sample of alcoholics: Study design and descriptive data. Substance Use and Misuse, 36(11), 1417-1441.
*Rychtarik, R. G., Foy, D. W., Scott, T., Lokey, L., & Prue, D. M. (1987). Five-six-year follow-up of broad-spectrum behavioral treatment for alcoholism: Effects of training controlled drinking skills. Journal of Consulting and Clinical Psychology, 55, 106-108.
*SAMHSA (2009). Working definition of recovery. Excerpt from National Summit on Recovery Conference Report, 2005. Rockville, MD: Center for Substance Abuse Treatment.
*Sanchez-Craig, M., Annis, H., Bornet, A., & MacDonald, K. (1984). Random assignment to abstinence and controlled drinking: Evaluation of a cognitive behavioral program for problem drinkers. Journal of Consulting and Clinical Psychology, 52, 390-403.

*Satre, D. D., Mertens, J. R., & Weisner, C. (2004). Gender differences in treatment outcomes for alcohol dependence among older adults. Journal of Studies on Alcohol, 65, 638-642.
*Saunders, W. M., Phil, M., & Kershaw, P. W. (1979). Spontaneous remission from alcoholism: A community study. British Journal of Addiction, 74, 251-265. doi:10.1111/j.1360-0443.1979.tb01346.x
*Savage, L. J., & Simpson, D. D. (1978). Illicit drug use and return to treatment: Follow-up study of treatment admissions to DARP during 1969-1971. American Journal of Drug and Alcohol Abuse, 5, 23-38.
*Schaefer, J. A., Cronkite, R. C., & Hu, K. U. (2011). Differential relationships between continuity of care practices, engagement in continuing care, and abstinence among subgroups of patients with substance use and psychiatric disorders. Journal of Studies on Alcohol and Drugs, 72, 611-621.
Schmidt, L. A., & Weisner, C. M. (2005). Private insurance and the utilization of chemical dependency treatment. Journal of Substance Abuse Treatment, 28, 67-76. doi:10.1016/j.jsat.2004.10.008
*Schuckit, M. A., Daeppen, J., Tipp, J., Hasselbrock, M., & Bucholz, K. K. (1988). The clinical course of alcohol-related problems in alcohol dependent and nonalcohol dependent drinking women and men. Journal of Studies on Alcohol, 59, 581-590.
*Schuckit, M. A, Schwei, M. G., & Gold, E. (1986). Prediction of outcome in inpatient alcoholics. Journal of Studies on Alcohol, 47, 151-155.
*Schuckit, M. A., Smith, T. L., Danko, G. P., Bucholz, K. K., Reich, T., & Bierut, L. (2001). Five-year clinical course associated with DSM-IV alcohol abuse or dependence in a large group of men and women. American Journal of Psychiatry, 158, 1084-1090.
*Schuckit, M. A., Smith, T. L., & Landi, N. A. (2000). The 5-year clinical course of high-functioning men with DSM-IV alcohol abuse or dependence. American Journal of Psychiatry, 157, 2028-2035.
*Schuckit, M. A., Tipp, J. E., & Bucholz, K. K. (1997). Periods of abstinence following the onset of alcohol dependence in 1,853 men and women. Journal of Studies on Alcohol, 58, 581-589.
*Schulenberg, J., O'Malley, P. M., Bachman, J. G., Wadsworth, K. N., & Johnston, L. D. (1996). Getting drunk and growing up: Trajectories of frequent binge drinking during the transition to young adulthood. Journal of Studies on Alcohol, 57, 289-304.
*Schulenberg, J. E., & Maggs, J. L. (2002). A developmental perspective on alcohol use and heavy drinking during adolescence and the transition to young adulthood. Journal of Studies of Alcohol, Sup. No. 14, 54-70.
*Schutte, K., Brennan, P., & Moos, R. (1994). Remission of late-life drinking problems: A 4-year follow-up. Alcoholism: Clinical and Experimental Research, 18, 835-844. doi:10.1111/j.1530-0277.1994.tb00048.x
*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, 322-334.
*Schutte, K. K., Moos, R. H., & Brennan, P. L. (2006). Predictors of untreated remission from late-life drinking problems. Journal of Studies on Alcohol, 67, 354-362.

*Schutte, K. K., Nichols, K. A., Brennan, P. L., & Moos, R. H. (2003). A ten-year follow-up of older former problem drinkers: Risk of relapse and implications of successfully sustained remission. Journal of Studies on Alcohol, 64, 367-374.
*Scott, C. K., Dennis, M. L., & Foss, M. A. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. Drug and Alcohol Dependence, 78, 325-338. doi:10.1016/j.drugalcdep.2004.12.005
*Scott, C. K., Foss, M. A., & Dennis, M. L. (2005). Pathways in the relapse-treatment-recovery cycle over 3 years. Journal of Substance Abuse Treatment, 28(Supplement 1), S63-S72. doi:10.1016/j.jsat.2004.09.006
*Sees, K. L., Delucchi, K. L., Masson, C., Rosen, A., Clark, H., Robillard, H.,…Hall, S. M. (2000). Methadone maintenance vs. 180-day psychosocially enriched detoxification for treatment of opioid dependence: A randomized controlled trial. Journal of the American Medical Association, 283(10), 1303-1310. doi:10.1001/jama.283.10.1303
*Sells, S. B., & Simpson, D. D. (1979). Evaluation of treatment outcome for youths in drug abuse reporting program (DARP): A follow-up study. In G. M. Beschner & A. S. Friedman (Eds.), Youth drug abuse: Problems, issues, and treatment (pp. 571-628). Lexington, MA: DC Heath.
*Selzer, M. L., & Holloway, W. H. (1957). A follow-up of alcoholics committed to a state hospital. Quarterly Journal of Studies on Alcohol, 18, 98-120.
*Shaw, G. K., Waller, S., Latham, C. J., Dunn, G., & Thomson, A. D. (1997). Alcoholism: A long-term follow-up study of participants in an alcohol treatment programme. Alcohol and Alcoholism, 32, 527-535.
*Shea, J. E. (1954). Psychoanalytic therapy and alcoholism. Quarterly Journal of Studies on Alcohol, 15, 595-605.
*Sherman, S. G., Hua, W., & Latkin, C. A. (2004). Individual and environmental factors related to quitting heroin injection. Substance Use & Misuse, 39(8), 1199-1214.
*Shore, J. H., & Von Fumetti, B. (1972). Three alcohol programs for American Indians. American Journal of Psychiatry, 128, 1450-1454. doi:10.1176/appi.ajp.128.11.1450
*Siegal, H., Li, L., & Rapp, R. (2002). Abstinence trajectories among treated crack cocaine users. Addictive Behaviors, 27, 437-449. doi:10.1016/S0306-4603(01)00184-8
*Silkworth, W. D. (1939). Psychological rehabilitation of alcoholics. Medical Record, 150, 65.
*Simpson, D. D., Joe, G. W., & Broome, K. M. (2002). A national 5-year follow-up of treatment outcomes for cocaine dependence. Archives of General Psychiatry, 59(6), 538-544.
*Simpson, D. D., Joe, G. W., Fletcher, B. W., Hubbard, R. L., & Anglin, M. D. (1999). A national evaluation of treatment outcomes for cocaine dependence. Archives of General Psychiatry, 56(6), 507-514.
Simpson, D. D., Joe, G. W., Lehman, W. E. K., & Sells, S. B. (1986). Addiction careers: Etiology, treatment and 12-year follow-up outcomes. Journal of Drug Issues, 16, 107-121.
*Simpson, D. D., & Lloyd, M. (1978). Alcohol and illicit drug use: Follow-up study of treatment admissions to DARP during 1969-1971. American Journal of Drug and Alcohol Abuse, 5, 1-22.
*Simpson, D. D., & Marsh, K. L. (1986). Relapse and recovery among opioid addicts 12 years after treatment. In F. M. Tims & C. G. Leukefeld (Eds.), Relapse and recovery in drug abuse

(NIDA Research Monograph 72, DHHS Publication No. 88-1473, pp. 86-103). Rockville, MD: National Institute on Drug Abuse.
*Simpson, D. D., Savage, L. J., & Lloyd, M. R. (1979). Follow-up evaluation of treatment of drug abuse during 1969 to 1972. Archives of General Psychiatry, 36, 772-780.
*Simpson, D. D., & Sells, S. B. (1983). Effectiveness of treatment for drug abuse: An overview of the DARP research program. Advances in Alcohol and Substance Abuse, 2, 7-29.
*Simpson, D. D., & Sells, S. B. (1990). Opioid addiction and treatment: A 12-year follow-up. Malabar, FL.: Krieger.
*Slutske, W. S. (2010). Why is natural recovery so common for addictive disorders? Addiction, 105, 1520-1521. doi:10.1111/j.1360-0443.2010.03035.x
*Smart, R. (1976). Spontaneous recovery in alcoholics: A review and analysis of the available research. Drug and Alcohol Dependence, 1, 277-285. doi:10.1016/0376-8716(76)90023-5
*Smart, R. (1978). Characteristics of alcoholics who drink socially after treatment. Alcoholism: Clinical and Experimental Research, 2, 49-52. doi:10.1111/j.1530-0277.1978.tb04693.x
*Smart, R. G. (1974). Employed alcoholics treated voluntarily and under constructive coercion: A follow-up study. Quarterly Journal of Studies on Alcohol, 35, 196-209.
*Smart, R. G. (1979). Female and male alcoholics in treatment: Characteristics at intake and recovery rates. British Journal of Addiction, 74, 275-281. doi:10.1111/j.1360-0443.1979.tb01348.x
*Smith, E. M., Cloninger, C. R., & Bradford, S. (1983). Predictors of mortality in alcoholic women: A prospective follow-up study. Alcoholism: Clinical and Experimental Research, 7, 237-243. doi:10.1111/j.1530-0277.1983.tb05449.x
*Smith, J. W., Schmeling, G., & Knowles, P. L. (1988). A marijuana smoking cessation clinical trial utilizing THC-free marijuana, aversion therapy, and self-management counseling. Journal of Substance Abuse Treatment, 5, 89-98. doi:10.1016/0740-5472(88)90018-9
*Snow, M. (1973). Maturing out of narcotic addiction in New York City. International Journal of the Addictions, 8(6), 921-938.
*Sobell, L. C., Cunningham, J. A., & Sobell, M. B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. American Journal of Public Health, 86(7), 966-972.
*Sobell, L. C., Sobell, M. B., Agrawal, S., Leo, G. I, Johnson-Young, L. Toneatto, T., & Somco, E. R. (2001, November). A longitudinal prospective study of recovery and relapse among untreated alcohol abusers. Paper presented at the 35th annual meeting of the Association for the Advancement of Behavior Therapy, Philadelphia, PA.
Sobell, L. C., Sobell, M. B., Connors, G. J., & Agrawal, S. (2003). Assessing drinking outcomes in alcohol treatment efficacy studies: Selecting a yardstick of success. Alcoholism: Clinical and Experimental Research, 27, 1661-1666. doi:10.1097/01.ALC.0000091227.26627.75
*Sobell, L. C., Sobell, M. B., Toneatto, T., & Leo, G. I. (1993). What triggers the resolution of alcohol problems without treatment? Alcoholism: Clinical and Experimental Research, 17, 217-224. doi:10.1111/j.1530-0277.1993.tb00752.x
*Sobell, M. B., & Sobell, L. C. (1973). Individualized behavior therapy for alcoholics. Behavior Therapy, 4, 49-72. doi:10.1016/S0005-7894(73)80074-7

*Sobell, M. B., & Sobell, L. C. (1976). Second year treatment outcome of alcoholics treated by individualized behavior therapy: Results. Behaviour Research and Therapy, 14, 195-215. doi:10.1016/0005-7967(76)90013-9
*Sobell, M. B., & Sobell, L. C. (1991). Recovery from alcohol problems without treatment. In N. Heather, W. R. Miller, & J. Greeley (Eds.), Self control and the addictive behaviors (pp. 198-242). New York: Maxwell Macmillan.
*Sobell, M. B., Sobell, L. C., & Gavin, D. R. (1995). Portraying alcohol treatment outcomes: Different yardsticks of success. Behavior Therapy, 26, 643-669. doi:10.1016/S0005-7894(05)80037-1
*Spicer, J., & Owen, P. (1985). Finding the bottom line: The cost impact of employee assistance and chemical dependency treatment programs. Center City, MN: Hazelden Foundation.
*Spooner, C., Mattick, R. P., & Noffs, W. (2001). Outcomes of a comprehensive treatment program for adolescents with a substance-use disorder. Journal of Substance Abuse Treatment, 20, 205-213. doi:10.1016/S0740-5472(01)00166-0
*Stall, R. (1983). An examination of spontaneous remission from problem drinking in the Bluegrass Region of Kentucky. Journal of Drug Issues, 13, 191-206.
*Stall, R., & Biernacki, P. (1986). Spontaneous remission from the problematic use of substances: An inductive model derived from a comparative analysis of the alcohol, opiate, tobacco, and food/obesity literatures. International Journal of the Addictions, 21, 1-23.
*Stephens, R., & Cottrell, E. (1972). A follow-up study of 200 narcotic addicts committed for treatment under the Narcotic Addict Rehabilitation Act (NARA). British Journal of Addiction, 67, 45-53. doi:10.1111/j.1360-0443.1972.tb01167.x
*Stephens, R. S., Babor, T. F., Kadden, R., Miller, M., & The Marijuana Treatment Research Group. (2002). The Marijuana Treatment Project: Rationale, design and participant characteristics. Addiction, 97(Suppl 1), 109-124. doi:10.1046/j.1360-0443.97.s01.6.x
*Sterling, S., Chi, F., Campbell, C., & Weisner, C. (2009). Three-year chemical dependency and mental health treatment outcomes among adolescents: The role of continuing care. Alcoholism: Clinical and Experimental Research, 33(8), 1417-1429. doi:10.1111/j.1530-0277.2009.00972.x
*Stinchfield, R., Niforopulos, L., & Feder, S. (1994). Follow-up contact bias in adolescent substance abuse treatment outcome research. Journal of Studies on Alcohol, 55, 285-289.
*Stinchfield, R., & Owen, P. (1998). Hazelden's model of treatment and its outcome. Addictive Behaviors, 23(5), 669-683. doi:10.1016/S0306-4603(98)00015-X
*Storbjork, J., & Room, R. (2008). The two worlds of alcohol problems: Who is in treatment and who is not? Addiction Research and Theory, 16(1), 67-84. doi:10.1080/16066350701578136
*Straus, R., & Bacon, S. (1953). Alcoholism and social stability: A study of occupational integration in 2,023 male clinic patients. Quarterly Journal of Studies on Alcohol, 12, 231-260.

*Substance Abuse and Mental Health Services Administration. (2003). Results from the 2002 National Survey on Drug Use and Health: National findings (Office of Applied Studies, NHSDA Series H-22, DHHS Publication No. SMA 03–3836). Rockville, MD: Author.
Substance Abuse and Mental Health Services Administration. (2009). Results from the 2008 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD., Figure 7.1; Table G.32.
*Swift, W., Hall, W., & Copeland, J. (2000). One year follow-up of cannabis dependence among long-term users in Sydney, Australia. Drug and Alcohol Dependence, 59, 309-318. doi:10.1016/S0376-8716(99)00131-3
*Taylor, C., Brown, D., Duckitt. A., Edwards, G., Oppenheimer, E., & Sheehan, M. (1985). Patterns of outcome: Drinking histories over ten years among a group of alcoholics. British Journal of Addiction, 80, 45-50. doi:10.1111/j.1360-0443.1985.tb05288.x
*Teesson, M., Mills, K., Ross, J., Darke, S., Williamson, A., & Havard, A. (2008). The impact of treatment on 3 years' outcome for heroin dependence: Findings from the Australian Treatment Outcome Study (ATOS). Addiction, 103(1), 80-88. doi:10.1111/j.1360-0443.2007.02029.x
*Temple, M. T., & Fillmore, K. M. (1985). The variability of drinking patterns and problems among young men, age 16-31: A longitudinal study. International Journal of the Addictions, 20, 1595-1620. doi:10.3109/10826088509047250
*Termorshuizen, F., Krol, A. Prins, M., & van Ameijden, E. C. (2005). Long-term outcome of chronic drug use: The Amsterdam Cohort Study among drug users. American Journal of Epidemiology, 161, 271-279. doi:10.1093/aje/kwi035
*Thornton, K. E. B., & Lazzarini, A. (2005). The use of reliability techniques to predict the recovery rate of recovering alcohol addicts. Journal of the American Society for Information Science and Technology, 56(4), 356-363. doi:10.1002/asi.20111
*Thorpe, J. J., & Perret, J. T. (1959). Problem drinking, a follow-up study. AMA Archives of Industrial Health, 19, 24-32.
Tillotson, K. J., & Fleming, R. (1937). Personality and sociologic factors in the prognosis and treatment of chronic alcoholism. New England Journal of Medicine, 217, 611-615.
*Timko, C., & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-step self-help groups: One-year outcomes. Drug and Alcohol Dependence, 90, 270-279. doi:10.1016/j.drugalcdep.2007.04.007
*Timko, C., Finney, J. W., Moos, R., & Moos, B. (1995). Short-term treatment careers and outcomes of previously untreated alcoholics. Journal of Studies on Alcohol, 56, 597-610.
*Timko, C., Moos, R. H., Finney, J. W., & Connell, E. G. (2002). Gender differences in help-utilization and the 8-year course of alcohol abuse. Addiction, 97, 877-889. doi:10.1046/j.1360-0443.2002.00099.x
*Timko, C., Moos, R. H., Finney, J. W., & Lesar, M. D. (2000). Long-term outcomes of alcohol use disorders: Comparing untreated individuals with those in Alcoholics Anonymous and formal treatment. Journal of Studies on Alcohol, 61, 529-540.
* Timko, C., Moos, R. H., Finney, J. W., & Moos, B. S. (1994). Outcome of treatment for alcohol abuse and involvement in Alcoholics Anonymous among previously untreated problem

drinkers. The Journal of Behavioral Health Services and Research, 21(2), 145-160. doi:10.1007/BF02521322
*Timko, C., Moos, R. H., Finney, J. W., Moos, B. S., & Kaplowitz, M. S. (1999). Long-term treatment careers and outcomes of previously untreated alcoholics. Journal of Studies on Alcohol, 60, 437-447.
*Tomlinson, K. L., Brown, S. A., & Abrantes, A. M. (2004). Psychiatric comorbidity and substance use treatment outcomes of adolescents. Psychology of Addictive Behaviors, 18, 160-169. doi:10.1037/0893-164X.18.2.160
*Tomsovic, M. (1970). A follow-up study of discharged alcoholics. Hospital and Community Psychiatry, 21, 94-97.
*Tomsovic, M. (1973). "Binge" and continuous drinkers: Characteristics and treatment follow-up. Quarterly Journal of Studies on Alcohol, 35, 558-564.
*Toneatto, A., Sobell, L. C., Sobell, M. B., & Rubel, E. (1999). Natural recovery from cocaine dependence. Psychology of Addictive Behaviors, 13, 259-268.
*Tuchfeld, B. S. (1981). Spontaneous remission in alcoholics: Empirical observations and theoretical implications. Journal of Studies on Alcohol, 42, 626-641.
*UKATT Research Team (2002). Effectiveness of treatment for alcohol problems: Findings of the randomised UK alcohol treatment trial (UKATT). British Medical Journal, 331, 541. doi:10.1136/bmj.331.7516.541
*United Kingdom Drug Policy Commission. (2008). A consensus definition of recovery. Retrieved June 24, 2010 from http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf
*U.S. Department of Health and Human Services (1997). NTIES: The National Treatment Improvement Evaluation Study final report. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, National Opinion Research Center at the University of Chicago.
*Vaglum, P., & Fossheim, I. (1980). Differential treatment of young abusers: A quasi-experimental study of therapeutic community in a psychiatric hospital. Journal of Drug Issues, 10, 505-516.
*Vaillant, G. E. (1966a). A 12-year follow-up of New York narcotic addicts: I. The relation of treatment to outcome. American Journal of Psychiatry, 122, 727-737. doi:10.1176/appi.ajp.122.7.727
*Vaillant, G. E. (1966b). Twelve-year follow-up of New York narcotic addicts. The natural history of a chronic disease. New England Journal of Medicine, 275, 1282-1288.
*Vaillant, G. E. (1966c). A twelve-year follow-up of New York narcotic addicts: IV. Some characteristics and determinants of abstinence. American Journal of Psychiatry, 123(5), 573-585. doi:10.1176/appi.ajp.123.5.573
*Vaillant, G. E. (1973). A 20-year follow-up of New York narcotic addicts. Archives of General Psychiatry, 29, 237-241.
*Vaillant, G. E. (1979). Paths out of alcoholism. In Evaluation of the alcoholic: Implications for research, theory and treatment (Research Monograph No. 5, pp. 383-394). Rockville, MD: National Institute of Alcohol Abuse and Alcoholism.
*Vaillant, G. E. (1983). The natural history of alcoholism: Causes, patterns, and paths to recovery. Cambridge, MA: Harvard University Press.

*Vaillant, G. E. (1988). What can long-term follow-up teach us about relapse and prevention of relapse in addiction? British Journal of Addiction, 83, 1147-1157. doi:10.1111/j.1360-0443.1988.tb03021.x
*Vaillant, G. E. (1995). The natural history of alcoholism revisited. Cambridge, MA: Harvard Univ. Press.
*Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. Archives of General Psychiatry, 53, 243-249.
*Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. Addiction, 98, 1043-1051. doi:10.1046/j.1360-0443.2003.00422.x
*Vaillant, G. E., Clark, W., Cyrus, C., Milofsky, E. S., Kop, J., Wulsin, V. W., & Mogielnicki, N. P. (1983). Prospective study of alcoholism treatment: Eight-year follow-up. American Journal of Medicine, 75, 455-463.
*Vaillant, G. E., & Milofsky, E. S. (1982). Natural history of male alcoholism. IV. Paths to recovery. Archives of General Psychiatry, 39, 127-133.
*Vallance, M. (1965). Alcoholism: A two-year follow-up study of patients admitted to the psychiatric department of a general hospital. British Journal of Psychiatry, 111, 348-356. doi:10.1192/bjp.111.473.348
*Van Amberg, R. J. (1943). A study of 50 women patients hospitalized for alcoholic addiction. Diseases of the Nervous System, 4, 246-251.
*Van Dijk, W. K., & Van Dijk-Koffman, A. (1973). A follow-up study of 211 treated male alcoholic addicts. British Journal of Addiction, 68, 3-24. doi:10.1111/j.1360-0443.1973.tb01217.x
*Verachai, V., Punjawatnun, J., & Perfas, F. (2003). The results of drug dependence treatment by therapeutic community in Thanyarak Institute on Drug Abuse. Journal of the Medical Association of Thailand, 86(5), 407-414.
*Vik, P. W., Cellucci, T., & Ivers, H (2003). Natural reduction of binge drinking among college students. Addictive Behaviors, 28, 643-655. doi:10.1016/S0306-4603(01)00281-7
*Voegtlin, W. L., & Broz, W. R. (1949). The conditioned reflex treatment of chronic alcoholism. X. An analysis of 3,125 admissions over a period of ten and a half years. Annals of Internal Medicine, 30, 580-597.
*Voegtlin, W. L., & Lemere, F. (1942). The treatment of alcohol addiction: A review of the literature. Quarterly Journal of Studies on Alcohol, 2, 717-803.
*Von Sydow, K, Lieb. R., Pfister, H., Hofler, M., Sonntag, H., & Wittchen, H.-U. (2001). The natural course of cannabis use, abuse and dependence over four years: A longitudinal community study of adolescents and young adults. Drug and Alcohol Dependence, 64, 347-361. doi:10.1016/S0376-8716(01)00137-5
*Waldorf, D., & Biernacki, P. (1979). The natural recovery from heroin addiction: A review of the incidence literature. Journal of Drug Issues, 9, 281-289.
*Waldorf, D., Reinarman,C., & Murphy, S. (1991). Cocaine changes: The experience of using and quitting. Philadelphia, PA: Temple University.
*Waldron, H. B. (1997). Adolescent substance abuse and family therapy outcome. In T. H. Ollendick & R. J. Printz (Eds.), Advances in clinical child psychology (pp. 199-234). New York: Plenum Press.

*Waldron, H. B. Slesnick, N., Brody, J. L., Turner, C. W., & Peterson, T. R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7- month assessments. Journal of Consulting and Clinical Psychology, 69, 802-813. doi:10.1037//0022-006X.69.5.802

*Walitzer, K. S., & Dearing, R. L. (2006). Gender differences in alcohol and substance use relapse. Clinical Psychology Review, 26, 128-148. doi:10.1016/j.cpr.2005.11.003

*Wall. J. H., & Allen, E. G. (1944). Results of hospital treatment of alcoholism. American Journal of Psychiatry, 100, 474-479. doi:10.1176/appi.ajp.100.4.474

*Walsh, D. C., Hingson, R. W., Merrigan, D. M., Levenson, S. M., Cupples, A., Hereen, T.,…Kelly, C. A. (1991). A randomized trial of treatment options for alcohol-abusing workers. New England Journal of Medicine, 325, 775-782.

*Walters, G. D. (2000). Spontaneous remission from alcohol, tobacco and other drug abuse: Seeking quantitative answers to qualitative questions. American Journal of Drug and Alcohol Abuse, 26, 443-460.

*Warner, L. A., Alegria, M., & Canino, G. (2004). Remission from drug dependence symptoms and drug use cessation among women drug users in Puerto Rico. Archives of General Psychiatry, 61(10), 1034-1041.

Warner, L. A., White, H. R., & Johnson, V. (2007). Alcohol initiation experiences and family history of alcoholism as predictors of problem-drinking trajectories. Journal of Studies on Alcohol, 68, 56-65.

*Watson, C. G. (1987). Recidivism in “controlled drinker” alcoholics: A longitudinal study. Journal of Clinical Psychology, 43, 404-412. doi:10.1002/1097-4679(198705)43:3<404::AID-JCLP2270430315>3.0.CO;2-4

*Watson, C. G., & Pucel, J. (1985). The consistency of posttreatment alcoholics’ drinking patterns. Journal of Consulting and Clinical Psychology, 53, 679-683. doi:10.1037/0022-006X.53.5.679

*Wattenberg, W. W., & Moir, J. B. (1954). Factors linked to success in counseling homeless alcoholics. Quarterly Journal of Studies on Alcohol, 15, 587-594.

*Weingardt, K. R., Baer, J. S., Kivlahan, D. R., Roberts, L. J., Miller, E. T., & Marlatt, G. A. (1998). Episodic heavy drinking among college students: Methodological issues and longitudinal perspectives. Psychology of Addictive Behaviors, 12, 155-167.

*Weisner, C., Delucchi, K., Matzger, H., & Schmidt, L. (2003a). The role of community services and informal support on five-year drinking trajectories of alcohol dependent and problem drinkers. Journal of Studies on Alcohol, 64(6), 862-873.

*Weisner, C., Matzger, H., & Kaskutas, L. A. (2003b). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. Addiction, 98, 901-911. doi:10.1046/j.1360-0443.2003.00438.x

*Weisner, C., Ray, G. T., Mertens, J. R., Satre, D. D., & Moore, C. (2003). Short –term alcohol and drug treatment outcomes predict long-term outcome. Drug and Alcohol Dependence, 71, 281-294. doi:10.1016/S0376-8716(03)00167-4

Westermeyer, J. & Peake, E. (1983). A ten-year follow-up of alcoholic Native Americans in Minnesota. Journal of Psychiatry, 140, 189-194.

*White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. Alcoholism Treatment Quarterly, 23(1), 3-15. doi:10.1300/J020v23n01_02
*White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. Journal of Substance Abuse Treatment, 33, 229-241. doi:10.1016/j.jsat.2007.04.015
*White, W. L. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? Substance Use and Misuse, 43(12&13), 1987-2000. doi:10.1080/10826080802297518
*White, W. L. (2010). Relapse is NOT a part of recovery. Posted at "http://www.facesandvoicesofrecovery.org" www.facesandvoicesofrecovery.org and "http://www.williamwhitepapers.com" www.williamwhitepapers.com
White, W. L., & Schulstad, M. (2009). Relapse following prolonged addiction recovery: Time for answers to critical questions. Counselor, 10(4), 36-39.
*Williams, R. J., & Chang, S. Y. (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcome. Clinical Psychology: Science and Practice, 7(2), 138-166. doi:10.1093/clipsy.7.2.138
*Wilson, L. G., & Shore, J. H. (1975). Evaluation of a regional Indian alcohol program. American Journal of Psychiatry, 132, 255-258.
*Winick, C. (1962). Maturing out of narcotic addiction. Bulletin on Narcotics, 14, 1-7.
*Winick, C. (1964). The life cycle of the narcotic addict and of addiction. U.N. Bulletin on Narcotics, 16, 1-11.
*Winters, K. C., Latimer, W. L., & Stinchfield, R. D. (1999). Adolescent treatment. In P. J. Ott, R. E. Tarter, & R. T. Ammerman (Eds.), Sourcebook on substance abuse: Etiology, epidemiology, assessment, and treatment (pp. 32-49). Boston, MA: Allyn and Bacon.
Winters, K. C., Stinchfield, R., Latimer, W. W., & Lee, S. (2007). Long-term outcome of substance-dependent youth following 12-step treatment. Journal of Substance Abuse Treatment, 33, 61-69. doi:10.1016/j.jsat.2006.12.003
*Winters, K. C., Stinchfield, R. D., Opland, E. O., Weller, C., & Latimer, W. W. (2000). The effectiveness of the Minnesota Model approach in the treatment of adolescent drug abusers. Addiction, 94(4), 601-612. doi:10.1046/j.1360-0443.2000.95460111.x
*Wojnar, M., Brower, K. J., Strobbe, S., Ilgen, M., Matsumoto, H., Nowosad, I.,…Burmeister, M. (2009). Association between Val66MET brain-derived neurotrophic factor (BDNF) gene polymorphism and post-treatment relapse in alcohol dependence. Alcoholism: Clinical and Experimental Research, 33(4), 693-702. doi:10.1111/j.1530-0277.2008.00886.x
*Wolff, S., & Holland, L. (1964). A questionnaire follow-up of alcoholic patients. Quarterly Journal of Studies on Alcohol, 25, 108-118.
*Xie, H., Drake, R. E., McHugo, G. J., Xie, L., & Mohandas, A. (2010). The 10-year course of remission, abstinence and recovery in dual diagnosis. Journal of Substance Abuse Treatment, 39, 132-140. doi:10.1016/j.jsat.2010.05.011
*Yates. W. R., Reed, D. A.. Booth, B. M., Mastgerson, B. H., & Brown, K. (1994). Prognostic validity of short-term abstinence in alcoholism. Alcoholism: Clinical and Experimental Research, 18, 280-283. doi:10.1111/j.1530-0277.1994.tb00015.x
*Zimberg, S. (1974). Evaluation of alcoholism treatment in Harlem. Quarterly Journal of Studies on Alcohol, 35, 550-557.

*Zywiak, W. H., Longabaugh, R., & Wirtz, P. (2002). Decomposing the relationships between pretreatment social network characteristics and alcohol treatment outcome. Journal of Studies on Alcohol, 63, 114-121.

Appendix A

Recovery Prevalence Studies among Community Populations

Abbreviations include: AOD = alcohol and other drug; IP = inpatient; OP = outpatient; SUD = substance use disorder; Tx = treatment; NA = not available in original study or paper in which study was reported, or ill-defined)

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Lemere, 1952-53	Histories of 500 deceased alcoholics obtained from surviving family members	Absence of alcohol-related problems at time of death		43% (33% by abstinence)
Jones, 1958	Physicians under compulsory community supervision for past narcotic addiction	NA		92%
Bailey, 1967	12 originally reported alcoholics who had achieved normal drinking	Absence of alcohol-related problems	5 years	58% (50% by sustained controlled drinking; 8% by abstinence)
Robins, 1967	Community sample of men addicted to heroin	Heroin abstinence		80%
Barchha, 1968	88 patients with current or past alcoholism identified within 392 consecutive general hospital admissions	At least one year without drinking-related problems		42%

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Cahalan, 1972 (Also reported in Cahalan, 1970)	978 males age 21-59	High severity heavy drinking or binge drinking in lifetime but not presently		55% (50% for heavy drinking; 60% for binge drinking)
Sobell, 1973	70	Abstinence or controlled drinking	6 months	49%
Robins, 1974	495 drug-positive soldiers returning untreated from Vietnam	Narcotic abstinence	1 year	98%
Robins, 1975	898 American soldiers serving in Vietnam; 495 who were drug positive at time of departure	Sustained remission from addiction	3 years	93%
Clark, 1976	615 of original community sample of 786	Remission of alcohol-related symptoms	4 years	59% remission for binge drinking and 78% remissions from early reported loss of control
Imber, 1976	83 men diagnosed as alcoholic in hospital emergency room with no alcoholism treatment provided	Continuous abstinence	1 and 3 years	19% at one year; 10% at 3 years
Roizen, 1978	521 untreated drinkers	Reduction of problems from baseline	4 years	40% (for those with serious alcohol problems at baseline)
Saunders, 1979	228 persons reporting that they drank too much in the past	Remission of past problem drinking		36%
Ojesjö, 1981	96 alcoholic men	Scoring of alcohol-related problems	15 years	30%

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Vaillant, 1982	110 inner-city youth who later developed alcohol problems	Abstinence or controlled drinking	40 years	39% (34.5% abstinent; 4.5% controlled drinking)
Armor, 1983	500 untreated males and females with alcohol problems	Abstention or non-problematic drinking	2+ years	16%
Donovan, 1983	432 high school sample; 205 college sample	Remission of problem drinking	6-7 years	53% for former HS males; 70% for former HS females; 50% for former male college students; 80% for former female college students
Vaillant, 1983	100 patients admitted for alcohol withdrawal	Remission of problem drinking	8 years	35%
Wester-meyer, 1983	45 Chippewa Indians admitted for alcohol problems	Remission of problem drinking	10	21%
Fillmore, 1984	186 men aged 21-29 and 40-49	Remission of problem drinking	7 years	32% of younger cohort; 21% of older cohort
O'Connor, 1985	133 alcoholics	Abstinence or social drinking	20 years	41%
Taylor, 1985	99 male alcoholics	Abstinence or untroubled drinking	11+ years	40%
Mackenzie, 1986	85 male alcoholics	Abstinence or light drinking	8	44%
McCabe, 1986	57 married alcoholics	Abstinence or asymptomatic drinking	16+ years	61% of living subjects (abstinence or controlled drinking)

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Hermos, 1988	1,517 community dwelling men	Abstinence or reduced drinking to non-problematic levels	9 years	27% of original community sample of men were in recovery at follow-up (4.9% quitters; 17.8% reducers) NOTE: Not all of the original sample had alcohol problems.
Kandel, 1989	Follow-up of 1,222 NY high school student drug users	No longer reporting marijuana or cocaine use	9-14 years	34% of men and 45% of women had stopped marijuana use; 49% of men and 56% of women had stopped cocaine use
Murphy, 1989	27 cocaine users in community population	Abstinence or controlled use	11 years	18.5% migrated from controlled to compulsive use and abstinence and 7% transitioned from controlled use to abstinence
Hasin, 1990	Follow-up of 1969 Cahalan & Room[160] community sample of 978 men over age 21; 71 initially indicating alcohol abuse and 109 indicating alcohol dependence	No longer reporting indicators of abuse or dependence	4 years	47% for alcohol abuse 39% for alcohol dependence
Muga, 1990	298 heroin addicts admitted to a general hospital	Abstention from heroin use	25 months	45.5%

[160] Cahalan, D. & Room, R. (1974). *Problem drinking among American men*. New Brunswick, NJ: Rutgers Center of Studies of Alcohol.

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Helzer, 1991	Epidemiologic Catchment Area Study community samples in multiple cities	Meeting lifetime abuse dependence criteria but not in past year		51% for all alcohol use disorders; remission rates varied across sites but all fell in the 45-55% ranges; most remission cases report span of problem (Robins & Reiger, 1991, reported remission rates in this same study as 59% for drug abuse/dependence and 54% for alcohol abuse/dependence, p. 344.)
Moos, 1991	1,844 late-life problem drinkers admitted for medical services	Absence of drinking problems	1 year	29% (30% of initial total sample self-reported former but not current alcohol problems.)
Miller, 1992	99 problem drinkers treated via behavioral self-control training	Abstinence or asymptomatic use in past 12 months	3.5, 5, 7, and 8 years	36% (22% abstinence; 14% asymptomatic drinking)
Leung, 1993	Native American village; original sample of 100	Abstinence	Average 15 years	50%
Kessler, 1994	8,098 community sample aged 15-54	Remission from DSM-III-R diagnostic criteria	Lifetime rates compared to past year rates	42.5% remission rate (26.6% met criteria for a lifetime SUD but only 11.3% for past 12 months)
Schutte, 1994	1,620 late-life problem drinkers earlier admitted to 1 of 2 hospitals for medical care	Multiple measures	4 years	21%

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Hasin, 1995	U.S. General population survey in 1988 (43,809)	Survey of former drinkers (8,057)		18.5% of U.S. adult population were former drinkers; 21% of former drinkers met DSM alcohol dependence criteria; 42% met DSM alcohol abuse criteria
Humphreys 1995	395 alcoholics who sought treatment but did not receive treatment	Not meeting DSM diagnostic criteria	3 and 8 years	49.4% in remission at 3 years; of those in remission at 3 years, 83.5% remained so at 8 years
Dawson, 1996	4,585 adults with prior alcohol dependence drawn from a national U.S. sample	Meeting lifetime but not past year criteria for alcohol abuse or dependence		72.2% (22.3% abstinence; 49.9% subclinical use)
Kendell, 1996	66 diagnosed but untreated alcoholics	Abstinence for previous 12 months or asymptomatic drinking	2-13 years	23% (15% abstinence and 8% normal social drinking)
Sobell, 1996a	Canadian national and Ontario population surveys of current/former adult drinkers and subset of problem and remitted drinkers	Absence of alcohol-related problems in past year	1+ year	10.5% remitted in Ontario; 3.1% remitted in national study; of the remissions in the national Canadian sample, 62% were abstinence and 38% moderation

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Vaillant, 1996	55 Harvard Undergrads and 150 inner city adolescents all meeting DSM criteria for alcohol abuse	Abstinence of more than 3 years or not meeting DSM criteria for abuse	Data reported on follow-up from age 40	50% for both groups
Hasin, 1997	Follow-up of 876 men in Cahalan & Room sample	No longer meeting DSM criteria for alcohol dependence	1 year	29% for alcohol dependence
Kandel, 1997	National Household Survey	Remission	1 year	75%
Cunning-ham, 2000	1,035 people with lifetime alcohol use disorders drawn from community survey of adult drinkers in Ontario, Canada	Remission for past 12 months		56.9% remission (11.5% abstinence)
Ojesjö, 2000	41 alcoholic men	Remission	46 years	39% for total sample; 52% for survivors; of these, 40% were abstinence and 60% were non-hazardous social drinking
Quintero, 2000	Navaho community sample	Remission	Lifetime but not past year	42.8%
Schuckit, 2000	435 highly educated men	Remission	5 years	82.5% for alcohol dependence; 69.6% for alcohol abuse
Swift, 2000	Survey of 200 long-term cannabis users	Reduced use	1 year	19% no use or use less than weekly

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Booth, 2001	733 problem drinkers identified from 12,000 households	Not meeting diagnostic criteria for alcohol abuse or dependence at any of the 3 follow-ups	6 months; 12 months; 18 months	38%
Newcomb, 2001	Community sample of 470 adults	Absence of DSM diagnostic criteria	4 years	62% for alcohol abuse; 48% for alcohol dependence
Price, 2001	841 Vietnam Veterans	Absence of AOD-related problems	25 years	33-48% across drug choices
Russell, 2001	221 untreated recovered alcoholics identified in community sample	Abstinence or not meeting hazardous drinking criteria for past year		Total sample was in recovery: 57.8% by abstinence; 42.2% via asymptomatic drinking 78% of recoveries had been maintained for 3+ years
Schutte, 2001	Community sample of late-life drinking problems: 140 in remission and 184 baseline problem drinkers	Absence of alcohol-related problems	10 years	30% for baseline problem drinkers; 71% who were remitted at 4 years remained so at 10 years; 25% of remitted were abstinent; 75% were drinking without problems

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Von Sydow, 2001	3,021 age 14-24 community sample in Munich, Germany	Remission from cannabis abuse or dependence	42 months	56.6% (13.8% abstinence; 42.8% deceleration of use to subclinical levels)
Weisner, 2002	111 community sample	Abstinence or non-problematic use	1 year	35% (12% abstinence; 23% non-problematic use)
Schutte, 2003	447 older former problem drinkers	Not meeting diagnostic criteria	10 years	89% (Those in non-abstinent recovery were more likely to relapse than those in abstinent recovery at baseline.)
Vaillant, 2003	54 former Harvard undergraduates and 140 socially disadvantaged Boston adolescents	Not meeting diagnostic criteria for alcohol abuse or dependence	60 years	21% abstinence and 10.5% controlled drinking in college group; 32% abstinence and 1% controlled drinking in former inner city adolescents.
Vic, 2003	249 college students with a history of binge drinking in high school	No binge drinking in 3 months		22% reported no binge drinking in past 3 months.
Sherman, 2004	200 inner-city heroin injectors	Heroin abstinence	3 years	27.5%
Dawson, 2005	4,422 adults with prior to past year alcohol dependence	Not meeting DSM diagnostic criteria for past year		47.7% in full remission (18.2% abstinent; 11.8% asymptomatic drinkers; 17.7% low-risk drinkers) 27.3% partial remission
Kessler, 2005a,b	9,282 US community sample	Remission		74% of those with lifetime SUD in remission

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
McAwee-ney, 2005	134 alcoholic men	Remission	9 years	46%
Termorshui-zen, 2005	899 chronic drug users in Amsterdam addicted to heroin, cocaine, or amphetamine	Abstinence of at least 4 months	20 years	27%
De Bruijn, 2006	7,076 community sample in Netherlands	No longer meeting diagnostic status for alcohol use disorder	3 years	89% remission of those initially meeting DSM abuse criteria; 67% remission of those initially meeting DSM dependence criteria
Rumpf, 2006	144 adults who achieved remission from alcohol dependence without formal help	Not meeting diagnostic criteria for alcohol abuse or dependence	2 years	91% 82% if all those lost to follow-up are considered not in remission
Compton, 2007		Meeting DSM criteria for drug abuse or dependence in lifetime but not in past year		80% (81.8% for drug abuse; 76.9% for drug dependence)
Dawson, 2007	2,109 people who earlier met criteria for remission of alcohol dependence	No longer meeting diagnostic criteria for alcohol dependence	3 years	49% for previously asymptomatic drinkers; 72.8% of low-risk drinkers; 93.7% of abstainers

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Gilder, 2007	525 Southwest California Indians—159 meeting lifetime criteria for cannabis dependence	Not meeting DSM criteria for cannabis dependence in 6 months before interview		65%
Hasin, 2007	43,093 adults	Meeting lifetime DSM criteria for alcohol abuse or dependence but not in past year		71.9% (72.6% for alcohol abuse; 69.6% for alcohol dependence)
Edens, 2008	442 men and women originally identified with alcohol dependence in community survey	Remission	14 years	90.7% for men and 79.3% for women (some with subclinical problems); 37% of men and 45% of women report past-year recovery without evidence of any alcohol-related problems
Hser, 2008	629 heroin users; 694 cocaine users; 474 methamphetamine users	Decreased/moderate /low use patterns	10 years	54.5% (14% decreasing use; 35.5% moderate use; 5% low use)

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Karno, 2008	12,297 individuals who met prior-to-past-year criteria for a substance use disorder	Not meeting diagnostic criteria in past year	Comparis on of lifetime and past year reports	73% of total sample in remission; 80% for past substance abuse; 66% for past substance dependence; 77% for prior alcohol use disorder; 77% for prior drug use disorder; 62% for those with both alcohol and drug use disorder
Perkonigg, 2008	Community survey of 3,021 14-24 year olds in Munich, Germany	No cannabis use in 12 months preceding follow-up	4 years	65% of users at baseline reported no use at follow-up; 30% of those who met criteria for cannabis abuse do not report any use 10 years later
Dawson, 2009	22,245 community sample	No longer meeting DSM diagnostic criteria	3 years	25% in full remission; 39% in partial remission
Evans, 2009	365 injection drug users in community	Cessation of drug injection for 3 or more months		29%
Jacob, 2009	420 men meeting lifetime criteria for alcohol dependence	Remission	15 years	50% of men meeting criteria for severe chronic alcoholism at age 41 no longer met those criteria at age 56

Lead Author of Study	Population and Sample Size	Recovery Definition	Follow-up Period (where applic-able)	Recovery Rate
Kalaydjan, 2009	5,692 respondents in National Comorbidity Survey Replication	Absence of diagnostic criteria for past 12 months	Compari-son of lifetime and past-year reports	79% for alcohol abuse; 75% for alcohol dependence
Lopez-Quintero, 2010	43,093 community sample with sub-samples ranging from 408 to 6,937	No longer meeting diagnostic criteria		Lifetime rates were 83.7% for nicotine dependence; 90.6% for alcohol dependence; 97.2% for cannabis dependence; 99.2% for cocaine dependence
Penick, 2010	202 Danish males at high risk for alcoholism	Remission of alcohol use disorder	40 years	88% for alcohol abuse; 58% for alcohol dependence
Brennan, 2011	399 older men and 320 older women	Abstinence and remission of drinking problems	20 years	Overall reduction in alcohol-related problems; 22-23% abstinent at 20-year follow-up

Appendix B

Recovery/Remission Rates in Adult Clinical Studies[161]

Abbreviations include: AOD = alcohol and other drug; IP = inpatient; OP = outpatient; SUD = substance use disorder; Tx = treatment; NA = not available in original study or paper in which study was reported, or ill-defined)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Superintendent's Report, 1868 (Reported in Howard,1949)	228 discharged inebriates from New York State Inebriate Asylum	"reformed at follow-up"	Variable, up to 6 years	50%
American Association for the Cure of Inebriates, 1870 (Proceedings, 1870)	Reports from asylum directors at 1870 meeting	NA	NA	33% to 63%
Chicago Washingtonian Home Report, 1870 (Proceedings, 1870)	71 discharged patients	NA	NA	75.9% (54.9% cured; 21% hopeful)
New York Inebriate Asylum 1874 report	First patients treated at asylum	Temperate and total abstainers	Not reported	66.5%

[161] This Table incorporates data from the Calabria et al., 2010 review of remission studies.

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Chamberlain, 1891	3,212 men treated at New York Christian Home for Intemperate Men	Religious conversion and sobriety	Not reported	63%
Crothers, 1893	3,380 inebriates treated at Fort Hamilton	Not Reported	Not Reported	59.5% (43% doing well; 16.5% improved)
Bramwell, 1913 (Cited in Voegtlin, 1942)	76 treated alcoholics	Not defined	Not defined	84% (36.8% cured; 47.3% benefited)
Sausailoff, 1925 (Cited in Voegtlin, 1942)	1,284 treated alcoholics	Not defined	Not defined	80% “favorably influenced”
Reid, 1926 (Cited in Voegtlin, 1942)	Unreported	Abstinence and improved	Unrepor-ted	33% cured; 33% improved
Kruse, 1927 (Cited in Voegtlin, 1942)	1,104 treated alcoholics	Abstinence or improved	2 years	52% (24.7% abstinent; 27.4% improved)
Kinzler, 1930 (Cited in Bowman, 1942)	354	Abstinence or improved	4 years	38.1% (30.5% abstinent)
Spelten, 1931	4,000 treated alcoholics	3 years of abstinence following discharge	Not defined	33%
Hoffman, 1932	34 treated alcoholics	Abstinence or improved	2 years	47% “cured”
Bratz, 1933 (Cited in Voegtlin, 1942)	Patients discharged from European inebriate sanitoria	Abstinence for 2 years following discharge	2+ years	25%
Tillis, 1933 (Cited in Bowman, 1942)	1,000 treated alcoholics	Abstinence or improved	2 years	52.1% (24.7% abstinent)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Wolf, 1933 (Cited in Voegtlin, 1942)	1,082 patients treated in German inebriate asylum	Abstinence	2 years	25%
Gabriel, 1935 (Cited in Bowman, 1942)	1,109 alcoholic patients	Abstinence or improved	Not reported	42.2% (28% abstinent)
Kuron, 1937 (Cited in Voegtlin, 1942)	Men treated at Salvation Army	Abstinence	Unrepor-ted	40%
Tillotson, 1937 (Cited in Voegtlin, 1942)	43 treated alcoholics	Abstinence or improved	NA	68.9% (48% abstinent; 20.9% improved)
Tokarsky, 1938 (Cited in Bowman, 1942)	525 treated alcoholics	Abstinence	NA	13%
Bloomberg, 1939	21 alcoholics treated with Benzedrine sulphate	Abstinence	NA	66.6% (38% with continuous abstinence)
Silkworth, 1939	Unreported number of AA members observed following detoxification and AA involvement	Abstinence	4 years	50%
Lemere & Voegtlin, 1940	538 alcoholic patients treated with aversive conditioning	Abstinence	4 years	64.3%
Bowman, 1941	Review of seven studies	Abstinence	2-4 years following treatment	25-30%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Durfee, 1942 (Cited in Voegtlin, 1942)	Unreported number of treated alcoholics	Abstinence of 1 year or greater	NA	75%
Hock, 1942 (Cited in Voegtlin, 1942)	2,000 AA members	Continual abstinence without relapse	6 years	35%
Pescor, 1943	4,766 narcotic addicts-Lexington	Narcotic abstinence	6 months to 5 years	13.5%
Van Amberg, 1943	50 women alcoholics	Abstinence	1 year	19.6% (10.9% abstinent; 8.7% via moderated drinking)
Wall, 1944	100 treated male alcoholics	Abstinence or decreased drinking and improved functioning	3-8 years	43% (24% abstinence; 19% drinking but improved)
Voegtlin, 1949	2,325 patients treated with aversive conditioning	Continuous abstinence	1-10.5 years	44.8% of whole sample (85% at 6 months; 70% at 1 year; 40% at year 4; 25% at year 10)
Lemere, 1950	4,096 alcoholic patients treated with aversive conditioning	Abstinence	1-13 years	51% at final follow-up (44% continuous abstinence; 39% abstinence for those who relapsed and were re-treated)
Lemere (& O'Hallaren), 1950	503 alcoholic patients	Abstinence	3 months to 3.3 years	57% abstinent since treatment

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Prout, 1950	100 male alcoholics	Abstinence or improved functioning	Up to 8 years	55% (25% abstinent; 30% improved)
Knight, 1951	75 patients treated in psychiatric hospital for opioid or barbiturate addiction	Abstinence and improved categories	Less than 2 years	36% (20% abstaining at follow-up; 16% improved)
Hoff, 1953	560 treated alcoholics	Abstinence or improved	5 years	79.2% (38.4% abstinence; 21.2% single relapse; 19.6% improved)
Wattenberg, 1954	770 homeless alcoholics	Abstinence	Variable	9%
Davies, 1956	50 treated alcoholics	Abstinence or improved	2 years	64% (14% abstinence; 50% much improved or improved)
Nørvig, 1956	114	Abstinence	6-8 years	32%
Pfeffer, 1957	60 treated alcoholic employees	Abstinence or drinking but improved in preceding two years	Up to four years	92% (80% abstinence; 12% changed drinking pattern)
Selzer, 1957	131 alcoholics treated at a state hospital	Absence of alcohol-related problems	6 years	22% continuous abstinence; 16% became “social drinkers”
Fox, 1959	251 alcoholic patients	Abstinence and social adjustment	2 years	39% (30% abstinence)
Miller, 1959 (cited in Edwards, 1966)	40 treated alcoholics	“success rate”	9 months	91%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Mindlin, 1959	173 treated alcoholics	Abstinence plus social adjustment	NA	50.3%
Thorpe, 1959	278 employees referred to medical department for alcohol-related problems	At least 1 year of abstinence or improved (work performance)	3-11 years	46.8% (18.3% abstinence)
Clancy, 1961	25 male patients treated at alcoholism clinic	Continuous abstinence	6 months	45%
Gerard, 1962	400 treated alcoholics	Abstinence or asymptomatic drinking	2-8 years	32% (18% abstinence; 14% asymptomatic drinking)
Hunt, 1962	1,881 patients discharged from Lexington	Abstinence from heroin use or irregular use	1-4.5 years	9.9% (6.6% abstinent; 3.3% irregular use)
Winick, 1962	16,725 narcotic addicts known to the Federal Bureau of Narcotics via arrest or institutionalization between 1953-1954	Becoming inactive—no record of arrests or institutionalization	5-6 years	65% became inactive
Brunn, 1963	303 treated alcoholics	Cured (abstinence or asymptomatic drinking) or changed (enhanced social psychological functioning)	2-3 years	47.7% (17.3% cured and changed; 3.5% cured only; 26.9% changed only)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Duvall, 1963	453 treated narcotic addicts	Voluntary narcotic abstinence	2 years and 5 years	17% at 2 years; 25% at 5 years
Rossi, 1963	149 male treated patients	Abstinence of drinking with mild effects	6 months	39.5% (9% abstinent; 39.5% drinking with mild effects)
Wolf, 1963	270 treated alcoholics	Abstinence	2+ years	62.4% abstinent
O'Donnell, 1964	122 treated narcotic addicts	Narcotic abstinence	1-24 years	41%
Clancy, 1965	90 male patients treated at alcoholism clinic	Improvement or abstinence	One year	45% (27% continuous abstinence)
Robson, 1965	100 treated alcoholics	Abstinence	10-46 months	62%
Vallance, 1965	68 male alcoholics	Improved	2 years	25%
Edwards, 1966	40 alcoholics	Good, fair, poor outcome	1 year	65% (55% good; 10% fair)
Kendell, 1966	50 male and female treated alcoholics	Remission via abstinence or "normal" drinking	4 years	22% abstinent; 10% "normal" drinking
Moore, 1966	Survey of 102 state hospitals on estimate of improvement rate for their alcoholic patients	"Improvement"	NA	39% less than 1 year; 33% more than 1 year

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Myerson, 1966	100 treated Skid-Row alcoholics	Abstinence, employment, and family reintegration	6 years	46% (22% fully rehabilitated; 24% improved drinking without community reintegration)
Rathod, 1966	100	Abstinence and benefited	2 years	52% (43% continuous abstinence; 9% benefited but not abstinent)
Vaillant, 1966a Vaillant, 1966c	100 male heroin addicts treated at Lexington	Heroin abstinence for 3 years or longer during follow-up period	12 years	46% drug free in the community at the time of death or follow-up (although 90% returned to drug use after treatment) 52% (30% continuous; 11% essentially abstinent; 4% with 3 years abstinence who later relapsed; 5% with sustained abstinence but last 2-year status unknown; 2% abstinent at death)[162]

[162] These numbers decline when secondary drug use is factored in: 14% substituted alcohol for heroin, with 6% suffering alcohol-related impairment to health or occupational functioning.

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Pemberton, 1967	50 male and 50 female alcoholics	"successful adjustment"	8-24 months	20% success with females; 36% success with males
Barchha, 1968	82 medical patients with secondary diagnosis of alcoholism	Remission and complete abstinence	NA	33.3%
Bowen, 1968	79 treated alcoholics	Abstinence	1 year	19% (25% for completers)
Gallant, 1968	19 treated alcoholics	Complete abstinence maintained for study period	1 year	26.3% for whole sample
Kissen, 1968	480 treated alcoholics	Multiple success criteria	3 years	3 treatment groups: success reported as 17.4%, 20%, and 19.5%
Pattison, 1968	32 treated male alcoholics	Abstinence or asymptomatic drinking	1 year	68.7% (34% abstinence; 34% asymptomatic drinking)
Pokorny, 1968	88 treated male alcoholic veterans	Abstinence of mild social drinking	1 year	57.9% (31.8% abstinent; 26.1% mild social drinking)
Reinert, 1968	156 treated alcoholics	Abstinence or social drinking	1 year	22.6% (20% abstinence; 2.6% non-problematic drinking)
Ritson, 1968	100 treated alcoholics	Abstinence or improved	6 months	69% (47% abstinent; 22% improved)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Ball, 1969	242 heroin addicts from Puerto Rico treated at Lexington	Continuous opioid abstinence for at least 3 years	7+ years	19.4%
Gillis, 1969	797 alcoholic patients treated in state hospital	Abstinence with and without minor relapses	1-4 years	41% (16% continuous abstinence; 25% abstinence with "occasional breaks")
O'Donnell, 1969	266 narcotic addicts treated at Lexington	Abstinence	12 years	23% (10% continuous abstinence; 13% "much abstinence")
Ferguson, 1970	115 American Indian alcoholics	Elimination of destructive drinking	2 years	22.6%
Lovibond & Cady, 1970	28 problem drinkers treated in first controlled drinking program	Improvement	16 weeks to 2 years	85% improvement at 16-60 weeks; 59% improvement at 2 years
Rohan, 1970	178 alcoholic veterans	Continuous or present abstinence	2-30 months	60% (31% continuous abstinence)
Tomsovic, 1970	260 treated alcoholics	Abstinence or improvement	3, 6, and 12 months	45% (18% abstinent; 5% much improved; 22% improved)
Fitsgerald, 1971	392 men and 192 women treated at state hospital for alcoholism	Continual abstinence; essential abstinence; asymptomatic use	4 years	44% (29% continual abstinence)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Goodwin, 1971	93 male alcoholic felons	No alcohol-related problems in the past 2 years	8-9 years	40%
Hunt, 1971	Review of multiple studies	Abstinence	1 year	20%
Kish, 1971	173 alcoholic veterans	Abstinence and improvement	1 year	48% (14.5% abstinence; 7.5% 1 relapse; 26% occasional drinking; 7.5% regular asymptomatic drinking)
Lanaenauer, 1971	252 narcotic addicts	Abstinence from opioids and other drugs	6 months	50%
Bowden, 1972	63 treated narcotic addicts	No opioid use for 6 months	NA	22%
Knox, 1972	54 male alcoholics treated at VA hospital	Abstinence during period of follow-up	4 years	15.9% abstinent
Levy, 1972	50 narcotic addicts	Abstinence or only isolated use	5 years	40% (18% abstinence; 22% only isolated use)
Shore, 1972	624 treated American Indian alcoholics	Abstinence or mostly abstinence with some relapse episodes		56% (28% abstinence; 28% mostly abstinence with some relapse episodes)
Stephens, 1972	200 male narcotic addicts committed under NARA	Narcotic abstinence for at least 6 months	2+ years	13%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Zimberg, 1972	78 treated alcoholics in Harlem	Abstinence or minimal use	1 year	42.3%
Snow, 1973	3,655 cases from New York City Narcotics Register	No reports indicating narcotic use	9 years	23%
Sobell, 1973	70 patients treated in controlled drinking program	Abstinence, controlled drinking, improved	3 years	50% (abstinent, controlled, or improved)
Tomsovic, 1973	179 alcoholic patients	Abstinence or improvement	1 year	65% (28% abstinence) for binge drinkers; 58% (31% abstinence) for continuous drinkers
Vaillant, 1973	100 narcotic addicts treated at Lexington	Prolonged opioid abstinence	20 years	35%
Van Dijk, 1973	211 treated male alcoholics		2.5-5.5 years	49% changed positively (22.5% abstinence; 10% moderation; 16.5% improved with sporadic excessive drinking)
d'Orban, 1974	66 treated narcotic addicts	"off narcotics" at point of follow-up	4 years	47% at point of follow-up

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Emrick, 1974	Survey of alcoholism treatment outcome literature	Variable	Variable	39.6% average recovery rate (33.8% by abstinence; 5.8% by controlled drinking)
Smart, 1974	100 employed alcoholics	Degrees of improvement	12-14 months	87% (76% highly improved; 11% moderately improved)
Emrick, 1975	Survey of 126 studies of psychologically oriented alcoholism treatments	Abstinence	Variable	13% of untreated abstinent at follow-up and 41% somewhat improved; 21% of minimally treated abstinent and 43% somewhat improved
Wilson, 1975	83 American Indian treated alcoholics	Complete abstinence in past year	18 months	44% improvement (28% complete abstinence)
Armor, 1976	2,339 treated alcoholics	Improvement: abstinence or asymptomatic drinking or cycling between the two	6 and 18 months	70% (24% by abstinence past 6 months) (This was reduced to less than 40% in a subsequent reanalysis published in Polich et al., 1980.)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Ewing, 1976	35 patients treated in experimental controlled drinking program	Asymptomatic drinking	27-55 months	0% of patients (high early attrition; only 9 patients attended more than 12 sessions; all patients resumed uncontrolled drinking with 64% subsequent abstinence at follow-up)
Hyman, 1976	54 alcoholics treated in OP clinic	Abstinence at follow-up	15 years	13%
Orford, 1976	65 treated alcoholics	Abstinence; abstinence with only 1 slip; asymptomatic drinking	2 years	29% (16.9% abstinent; 12.3% asymptomatic drinking)
Anderson, 1977	110 alcoholic men treated in VA alcoholism treatment unit	Abstinence or non-destructive drinking	1 year	82% (38% abstinence; 44% non-destructive drinking)
Costello, 1977	Analysis of 80 alcoholism treatment outcome studies	Abstinence	At least 12 months	26%
Gillis, 1977	7 addictive drinkers in South Africa	Improvement/ abstinence	6 years	42.9% (28.6% completely abstinent)
Ogborne, 1977	100 TC residents	Abstinence from drugs other than alcohol and reduced use	6+ months	29% (17% abstinence; 12% sporadic use)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Miller, 1978	46 voluntary problem drinkers and 17 court-referred problem drinkers completing 1 of 3 controlled drinking treatment programs	Abstinence or controlled drinking	12 months	58.7% (8.7% by abstinence; 50% by controlled drinking)
Savage, 1978	1,409	Abstinence from opioid and non-opioid drug use	4-6 years	42% in first 3 years
Simpson, 1978	1,409 patients in drug treatment programs	Abstinence	3 years	14% abstinent from alcohol; 76% abstinent from opioids; 78% abstinent from non-opioids other than marijuana; 43% abstinent from marijuana
Bromet, 1979	262 “low bottom” and 167 “high bottom” treated alcoholics	Abstinence or asymptomatic drinking	6-8 months	37% for “low bottom” patients (15% abstinence; 22% drinking moderately) 75% for “high bottom” alcoholics (46% abstinence; 29% drinking moderately)
Harrington, 1979	51 narcotic offenders	Opioid abstinence	20 years	2% voluntarily abstinent

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Kern, 1979	132 treated alcoholics	Abstinence	6 months	42% continuous abstinence; additional 18% abstinent for 5 of 6 months
Paredes, 1979	342 treated alcoholics	Abstinence or asymptomatic use for those not in remission at admission	6, 12, and 18 months	54% at 6 months; 65.7% at 18 months
Smart, 1979	157 male and 157 female treated alcoholics	Abstinence and improvement	1 year	42.7% for men (14% abstinence; 28.6% much improvement); 47.1% for females (14.6% abstinence; 32.5% much improvement)
Finney, 1980	113 patients treated for alcoholism	Abstinence past month	2 years	68% at 6 months; 40% at 18 months
Finney, 1981	131 treated alcoholics	Abstinence and controlled drinking	2 years	42.7% at 2 years 72.5% at 6 months (65.6% abstainers; 5.3% moderate drinkers)
Maddux, 1981	248 opioid addicts	Opioid abstinence	30 years	24% at four-year follow-up
Polich, 1981	548 male alcoholics treated in 1 of 5 residential programs	Abstinence or controlled drinking	4 years	46% (28% abstinent; 18% drinking without dependence symptoms)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Gottheil, 1982	171 treated alcoholic veterans	Abstinence or controlled drinking	6, 12, and 24 months	54.9% at 6 months; 54.9% at 12 months; 55.5% at 24 months
Pettinati, 1982	150 men and 75 women treated for alcoholism	Abstinence and quality of adjustment	4 years	76% (46% with abstinence and good adjustment)
Edwards, 1983	99 married alcoholics	Social adjustment	11 years	40% "good outcome" (19% continuous abstinence; 8% social drinking)
Gordon, 1983	60 male patients treated at a drug clinic in London	Lack of conviction or knowledge of drug use 5 years preceding follow-up	10 years	40.8%
Graeven, 1983	151 treated and untreated heroin addicts	Heroin abstinence	1-9 years	52% for untreated group; 50% for those with 1-2 treatment experiences
Miller, 1983	82 treated problem drinkers	Abstinence, controlled drinking, improved	2 years	54.8% (14.6% abstinence; 36.5% controlled drinking; 15.8% improved)
Smith, 1983 (reported in Finney, 1991)	NA	Remission	11 years	47%
Vaillant, 1983	110 men and women admitted to inpatient alcoholism treatment ward	Abstinence of 3 past years or longer at follow-up	8 years	34% (59% if six-month abstinence criteria within 8 years was used)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Sanchez-Craig, 1984	70 early-stage problem drinkers	Abstinence or controlled drinking	2 years	73% in 1 treatment group; 72% in second group
Cottrell, 1985	83 British opioid addicts	Opioid abstinence	11 years	44.6%
Helzer, 1985	1,289 treated alcoholics	Remission	2-4 years	33.4% (15% abstinent; 4.6% mostly abstinent; 1.6% stable moderate drinking; 12.2% heavy non-problem drinkers)
O'Connor, 1985	133 alcoholics	Remission	20 years	82.5% (67.5% abstinence; 15% asymptomatic drinking)
Elal-Lawrence, 1986	139 alcoholics who had received inpatient treatment	Abstinence or asymptomatic drinking	1 year	67.5% (31.6% abstinence; 35.9% controlled drinking)
Fuller, 1986 (Cited in Miller 2001)	NA	Abstinence	1 year	19.2%
Hubbard, 1986	2,280 clients admitted for detox or treatment	Abstinence	4-6 years	12%
Kosten, 1986	268 opioid addicts	Continuous abstinence	2.5 years	30%
Makenzie, 1986	85 male alcoholics treated in inpatient treatment center	Change in drinking classification	8 years	44% (27.7% abstinent; 7% light drinkers; 9% drinking then abstinent at end of follow-up)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
McCabe, 1986 (Reported in Finney, 1991)	57 formerly treated, married alcoholics	Remission	16.6 years	65%
Nordstrom, 1986	70 male alcoholics	No problems at follow-up	20 years	57.1%
Simpson, 1986	490 opioid addicts	Opioid abstinence	12 years	57% opioid abstinent at 12-year follow-up
Nordström, 1987	55 male treated alcoholics	Abstinence or asymptomatic drinking	20 years	58% (20% abstainers; 38% controlled drinkers)
Rychtarik, 1987	43 patients treated for alcoholism with behavioral therapy	Abstinence and absence of alcohol-related problems during 6 months preceding follow-up	5-6 years	35% (21% by abstinence; 14% via moderate drinking)
Watson, 1987	42 treated alcoholics previously identified by collaterals as controlled drinkers following treatment	Absence of alcohol consumption that interfered with subject's life, relationships, and work	2 weeks to 18 months after discharge	47% were controlled or abstinent at last follow-up; 69% were rated as uncontrolled drinking or institutionalized during one of the follow-ups in the first year
O'Sullivan, 1988	300 alcoholics with and without affective disorder	Abstinence	2 years	38.5% (44% unipolar; 33% bipolar; 38% primary alcoholism)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Smith, 1988	60 adult patients treated for cannabis dependence	Continuous abstinence from cannabis	6 and 12 months	75% at 6 months; 84.2% at 12 months
Dorus, 1989 (Cited in Miller, 2001)	457 male alcoholic veterans treated with lithium	Abstinence	12 months	33.1%
Gossop, 1989	80 patients treated for opioid addiction	Opioid abstinence	6 months	51% (19% continuous abstinence; 31% used after treatment but no longer using at follow-up)
Cross, 1990	200 male and female treated alcoholics	Remission	10 years	76% of surviving sample was in remission
Joe, 1990	490 treated narcotic addicts	Narcotic abstinence	12 years	75%
Keso, 1990	141 employed alcoholics treated for alcoholism	Abstinence	1 year	26.3% in Hazelden-type treatment; 9.8% in traditional treatment
Loosen, 1990	29 alcoholic men abstinent for 2 or more years	Continuous abstinence	2 years	79% maintained their recoveries; 21% who resumed alcohol use all had less than 5 years of sobriety
Finney, 1991	124 treated patients/families	Multiple criteria including absence of alcohol-related problems	2 years, 10 years	57% at 10 years

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Walsh, 1991	227 workers referred for alcoholism treatment	Abstinence	2 years	41% abstinent at follow-up; 23% continuous abstinence
Booth, 1992	100 patients treated for problem drinking	Success: No more than 7 days of heavy drinking in past 12 months	1 year	27% "successful"
Frawley, 1992	156 patients admitted for inpatient treatment	Abstinence at follow-up	1 year	53%
Hoffman, 1992	8,087 inpatients and 1,663 outpatients treated for addiction	Abstinence	6 months and 12 months	60% for inpatients; 68% for outpatients at one year; 67% for inpatients; 75% for outpatients at 6 months
Powell, 1992	360 co-morbid male alcoholics	Abstinence or only occasional drinking	1 year	35% (25% continuous abstinence; 10% only occasional drinking)
Carroll, 1993	100 AA members	Continuous abstinence since joining AA	7 days to 33 years	65%
Hser, 1993	581 male narcotic addicts in CA civil commitment program	Self-reported abstinence and negative urine screen for opiates	24 years	20-22% reported abstinence; 25% negative in drug screen
Kosten, 1993	72 patients treated for cocaine dependence	Abstinence	6 months	31.9% abstained for 3 weeks or longer during study

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Langle, 1993	96 alcoholic patients	Complete abstinence	5 years	28.1%
McLellan, 1993	198 employed alcohol or cocaine dependent patients	Continuous abstinence	6 months	59%
Carroll, 1994	121 treated cocaine dependent individuals	Continuous abstinence following treatment	1 year	28%
Timko, 1994	515 initially untreated problem drinkers	Abstinence past 6 months	1 year	16.3% no treatment; 41% AA only; 29% outpatient treatment; 52% inpatient treatment
Yates, 1994	299 male patients treated for alcoholism in IP unit	Continuous abstinence	1 year	54.5% at 3 months; 37.2% at 6 months
Bartels, 1995	Follow-up of 148 patients with severe mental illness and substance use disorder	Abstinence	7 years	30% (25% for alcohol use disorders and 35% for drug use disorders)
Christo, 1995	101 treated drug users abstinent from their drug choice at baseline	Abstinence	6 months	46%
Humphreys, 1995	135 problem drinking individuals	Absence of alcohol-related problems	3 years	69.8% (21.5% abstinent; 48.3% moderate drinkers)

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Miller, 1995	8,080 treated patients	Abstinence	NA	60%
Paille, 1995	538 patients	Abstinence and reduced use	12 months	34.7% and 27.7% in two main treatment groups
Timko, 1995	439	Abstinence for at least 6 months	3 years	40%
Hasin, 1996	127 dually diagnosed patients	Remission of alcoholism and depression	5 years	74% (66.1% remission of alcoholism and depression; 7.9% remission of alcoholism but not depression)
Hoffman, 1996	184 cocaine dependent individuals	Cessation of regular cocaine use	1 year	77%
Jin, 1996	77 male alcoholics with at least 18 months of continuous abstinence	Abstinence	2-17 years	69% maintained abstinence throughout follow-up; Risk of relapse declines after 5 years of abstinence
Lowman, 1996	563 treated alcoholics	Abstinence	1 year	25.5%
Lerner, 1997	72 heroin addicts treated with naltrexone	Remission/no readdiction	5 years	81.8%
Ouimette, 1997	3,698 treated veterans	Abstinence	12 months	20.8%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Patterson, 1997	127 white male alcoholics	Complete abstinence	5 years	43% abstinent year prior to 5-year follow-up; 36% for complete five years
Project Match, 1997	952 clients treated in OP; 7,743 in aftercare Tx	Complete abstinence through follow-up period	12 months	19% of OP clients; 35% of aftercare clients
Shaw, 1997	112 treated alcoholics	Abstinence	9 years	85% (53% abstinent; 15% controlled; 16% improved)
Carroll, 1998	122 patients treated for alcohol/cocaine abuse	Alcohol and cocaine abstinence for at least 3 weeks during treatment		5 treatment conditions: 48%; 46%; 22%; 22%; and 6%
Project Match, 1998	806 treated patients diagnosed with alcohol abuse or dependence	Multiple criteria, including abstinence	37-39 months	30%
Stinchfield, 1998	1,083 MN Model Treatment	Abstinence and reduced drinking	1 year	88% (53% abstinence; 35% reduced AOD use)
Curran, 1999	298 male alcoholics treated in VA	Abstinence at all follow-ups	3, 6, 9, and 12 months	26.2% at 12 months
Gossop, 1999	408 English drug users admitted to residential drug treatment	Abstinence from all drugs during 3 months preceding follow-up	1 year	37%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Hser, 1999	507 patients treated for cocaine dependence in 18 residential programs	Cocaine abstinence during entire follow-up period	1 year	63% for first admissions; 50% for repeat admissions
Simpson, 1999	1,605 patients treated for cocaine dependence	Cessation of regular use; absence of cocaine-related problems	1 year	77% remitted from regular cocaine use; 58% remitted from cocaine-related problems
Stephens, 1999 (Reported in McRae, 2003)	212 treated cannabis dependent adults	Abstinence and improved categories	1 year	36% (17% abstinence; 19% improved)
Bacchus, 2000	104 opiate addicts	Opioid abstinence at follow-up	2-3 years	58%
Brecht, 2000	98 patients treated for methamphetamine dependence	Methamphetamine abstinence	19 months	49%
Byrne, 2000	Methadone patients	Heroin abstinence for 3 months	8+ years	39%
Foster, 2000	82 alcohol-dependent men and women admitted to detox	Abstinence	12 weeks	39%
Hser, 2000	242 treated heroin addicts in CA civil commitment programs	Heroin abstinence at follow-up	33 years	23% of total original sample; 55.8% of interviewed survivors

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Moos, 2000	21,000 patients treated in VA for a substance use disorder	Abstinence	1 year	42% without mental health care added; 52.9% with mental health care added
Ojesö, 2000	41 alcoholic males	No longer meeting DSM diagnostic criteria	40 years	52% of survivors
Sees, 2000	858 methadone patients	Cessation of illicit opioid use	12 months	50%
Stephens, 2000 (Reported in McRae, 2003)	291 cannabis dependent adults	Abstinence	16 months	28-29% across two study groups
Timko, 2000	466 alcoholic men	No longer meeting DSM criteria/abstinence	8 years	Remission at 8 years: 62.1% AA only; 55.4% treatment only; 63% AA and treatment; Abstinence at 8 years 48.5%; 45.9%; and 57.7% respectively
Walters, 2000	Analysis of studies published between 1984-1997 of spontaneous remission of AOD problems	Remission or complete abstinence	1-27 years	26.2% average remission; 18.2% complete abstinence
Haver, 2001	120 Swedish female alcoholics	Remission	2 years	57%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Hser, 2001	242 treated heroin addicts in CA civil commitment programs	5 years of heroin abstinence prior to follow-up	33 years	43%
Miller, 2001	Review of 7 large multisite alcoholism treatment outcome studies	Abstinence	1 year	34.5% (Average of 24.1% 12 months continuous abstinence and 10.4% moderated drinking)
Schuckit, 2001	1,346	Abstinence and remission	5 years	29% in remission at 1 year; 33% remission for alcohol dependence at 5 years; 50% remission for alcohol abuse at 5 years
Siegel, 2001	229 treated crack cocaine users	Abstinence	6 and 12 months	54.6% at 6 months; 46.3% at one year
Galanter, 2002	47 cocaine dependent patients	Urine negative for cocaine for 3 sessions preceding follow-up	12 weeks	43%
Gossop, 2002	242 clients treated in residential programs	Complete abstinence from heroin	12 months	40%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Gossop, 2002	549 treated clients in 54 UK programs	Abstinence from all primary and secondary drugs during 3 months prior to follow-up	1 and 2 years	35% at year 1 and 37% for year 2 for residential programs; 15% for year 1 and 24% for year 2 in community OP clinics.
Greenfield, 2002	100 alcoholics treated following inpatient treatment	No alcohol use in prior 12 months	1 year	24%
Hasin, 2002	250 alcohol, cocaine, or heroin dependent patients	Remission	6, 12, and 18 months	47% with remission of at least 26 consecutive weeks; 18% with continuous abstinence; 26% with sustained remission
Moyer, 2002	Meta-analysis of treated and untreated controls	Abstinence	Variable	21% for untreated; 43% for treated sample
Okruhlica, 2002	351 heroin dependent patients	Opioid abstinence	3 years	51%
Prendergast, 2002	Meta-analysis of 78 studies of drug treatment	Success rate		Average 57% success rate across 78 studies
Rawson, 2002	114 methamphetamine users admitted to treatment	Methamphetamine abstinence	2-5 years	82.5%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Ritsher, 2002	2,805	Not meeting DSM diagnostic criteria at time of follow-up	2 years	25% at 1 year; 28% at 2 years
Siegal, 2002	229 treated crack cocaine users	Cocaine abstinence	18 months	63%
Simpson, 2002	708 clients treated for cocaine dependence	No cocaine use in the past 12 months	1 and 5 years	42%
Stephens, 2002	450 treated adults with cannabis dependence	Cannabis abstinence in previous 90 days	4 months	22.6%
Timko, 2002	466 patients treated for an alcohol use disorder	Abstinence, no alcohol-related problems, remission	8 years	At one year, abstinence 68.9% for women and 58.3% for men; no drinking problems 58.7% for women and 43.6% for men; remission 51.9% for women and 40.8% for men)
UKATT Research Team, 2002	689 patients treated for alcohol problems	Reduction in alcohol problems	3 months and 12 months	No % of abstinence rate reported; total sample reported increase in days of abstinence to 46%, and alcohol-related problems had decreased for sample by 50%
André, 2003	20 violent patients treated for addiction	Abstinence	3-24 months	60%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Bond, 2003	367 men and 288 women seeking alcohol treatment	Abstinence	1 and 3 years	52.6% at one year; 47.7% at 3 years
Dennis, 2003	448 treated adults	Not in need of treatment as assessed by multiple criteria	24 months	51% for total sample
Flynn, 2003	432 outpatient methadone treatment patients	Multiple criteria—no opioid or cocaine use, no daily alcohol use, no criminality	5 years	28%
Gerra, 2003	265 methadone maintenance patients	Abstinence from illicit drugs	Variable	35.5%
Gossop, 2003	418 patients treated in 54 UK addiction treatment agencies	Abstinence from illicit drug use	1, 2, and 4-5 years	26% of methadone patients and 38% of residential patients were abstinent at 4-5 years
Moore, 2003	82 patients treated for cannabis dependence	Abstinence	6 months	29%
Ouimette, 2003	193	Abstinence or absence of AOD-related problems	5 years	27%
Verachai, 2003	247 persons treated for drug dependence in a TC	Abstinence from heroin at follow-up	5 years	71%
Weisner, 2003a	784 patients treated for a substance use disorder	Abstinence 30 days prior to follow-up	6 months and 5 years	59% at 6 months; 52% at 5 years

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Rawson, 2004	978 patients admitted for methamphetamine dependence	Urine sample free of methamphetamine at follow-up	6 months	69%
Satre, 2004	92 treated alcohol dependent patients	Abstinence in prior 30 days	6 months	79.3% of women; 54% of men
Aharonovich, 2005	250 adult patients treated for heroin, cocaine, or alcohol dependence	At least 26 weeks of abstinence following discharge	6, 12, and 18 month follow-up	53%
Bottlender, 2005	74 patients treated in OP alcoholism clinic	Abstinence	3 years	55% (43% abstinence; 12% improved)
Dennis, 2005	1,271 treatment admissions	Abstinence for at least 12 months	3 years	47%
Domino, 2005	292 treated health care professionals	Continuous abstinence	1-5 years	74.6%
Grella, 2005	951 patients admitted to addiction treatment	Abstinence in past 6 months	3 years	46%
Ilgen, 2005	2,967 patients treated in VA addiction treatment units	Abstinence during 3 months prior to follow-up	1 year	31%
Kaskutas, 2005	349 dependent drinkers entering treatment	Abstinence 30 days prior to follow-up	5 years	46% for low AA attenders and 86% of high AA attenders at one year

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Kelly, 2005	2,095	Abstinence and remission	1 and 5 years	45.4%, 49.8%, and 46.4% remission across 3 study groups (abstinence rates were 39%, 44.7%, and 41.3%)
Mann, 2005	70 patients treated for alcoholism	Abstinence	5, 10, 16 years	68% (54.2% abstinent; 14.2% improved)
Moos, 2005	461 help-seekers who received or refused treatment	Multiple criteria on alcohol-related problems	1, 3, 8, and 16 years	24% for no help group; 42% for helped group
Rathod, 2005	86 patients treated for heroin addiction	Opioid abstinence	33 years	36% of original cohort—80% of those still living were not using opioids
Ray, 2005	604 patients treated for a substance use disorder	Abstinence for 30 days prior to follow-up interview	5 years	54%
Scott, 2005	448	No use or problems while living in the community	2 years	42%
Scott, 2005	1,326	Abstinence	3 years	41.2%
Chi, 2006	104 dual diagnosis patients	Abstinence	1 year	36.5% alcohol abstinence; 52.1% drug abstinence
Flynn, 2006	708 patients treated for cocaine dependence	Remission	5 years	33%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Havard, 2006	495 treated heroin addicts	Heroin abstinence past month	1 year	59%
Hser, 2006	321 treated cocaine-dependent men	Cocaine abstinence for more than 5 years	12 years	52% (25% reported using marijuana; 9% reporting daily alcohol use)
Krampe, 2006	180 treated chronic alcoholics	Abstinence	7 years	60% at follow-up; 26% continuous abstinence throughout study
Lozano, 2006	291 adult cannabis users	Abstinence or moderation	16 months	61% (40.8% abstinence; 21.4% moderation)
Moos, 2006a	461 people seeking help for alcohol problems	Remission	16 years	62% for helped group; 43% for no help group
Moos, 2006b	628 individuals seeking assistance from alcohol information and referral center	Abstinence	Subjects participa-ting 27+ weeks	55.8% for treatment group; 67% for AA participation group
Schutte, 2006	580 of 2,318 community sample with lifetime history of drinking problems	Remission	4 and 10 years	77.5% (56.9% remission with no treatment; 20.7% remission with treatment)
Cleveland, 2007	82 members of a collegiate recovery program	Abstinence	2+ years	73% continuous abstinence

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Dennis, 2007	1,162 treatment admissions	Abstinence	8 years	43% not using at follow-up; of these, 46.3% were abstinent less than a year; 25% 1-3 years; 12.9% 3-5 years; and 15.4% more than 5 years
Grombaek, 2007	148 patients treated for alcohol dependence	Abstinence	1 year	35% of MN model clinic patients continuously abstinent; 20% of public clinic patients; 53% of MN clinic patients abstinent for month prior to follow-up; 43% of public clinic patients
Hser, 2007	242 treated heroin addicts	5 years of abstinence from heroin use	33 years	43%
Jason, 2007	897 Oxford House residents	Abstinence since leaving Oxford House	1 year	81.5%
Laudet, 2007	219 patients treated for a substance use disorder	Abstinence since last follow-up	1 year	55% since last follow-up; 21.5% continuous abstinence throughout study

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Moos, 2007	628 individuals who contacted alcohol information center	Remission defined as abstinence or light-to-moderate drinking, no alcohol problems, and consuming no more than 2 ounces of alcohol on any drinking day—all in past 6 months	16 years (1-, 3-, 8-, and 16-year follow-up points)	41% of total sample achieved remission; 65% of those who achieved remission had sustained this state at 16-year follow-up; 61% at 3 years for treated sample; 36% at 3 years for untreated sample
Ribeiro, 2007	131 crack cocaine users admitted to detox in Sao Paul, Brazil	Abstinence from cocaine	5 years	20% at 2 years; 40% at 5 years
Teesson, 2007	615 heroin users enrolled in Australian Treatment Outcome Study	Cessation/reduction of heroin use in past month; cessation of other drug use	3 years	67% reduction of heroin use 25% reduction of all drugs
Timko, 2007	345	Abstinence	1 year	41% and 51.4% for standard and experimental group
Dias, 2008	Follow-up of 131 treated crack cocaine users	Cocaine abstinence	2, 5, and 12 years	22.1% at 2 years; 39.7% at 5 years; 32% at 12 years
Fu, 2008	499 patients	40%	18 months	40% for African Americans and 47% for Caucasians

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Ilgen, 2008	420 treated persons with alcohol use disorders	Absence of alcohol-related problems	1, 3, and 8 years	52% at one year (36% abstinent; 16% drinking without problems); 52% of those reporting moderated drinking at year 1 experienced later alcohol problems
Laudet, 2008	312 crack cocaine and heroin users	Abstinence at follow-up	1 year	66.1%
McLellan, 2008	802 physicians treated for a substance use disorder	Completion of 5 years of monitoring; abstinence	5 years	81% completed 5 years of supervision; 81% had no positive urine screens in the 5-year period; of those who did, 74% did not retest later as positive
Teesson, 2008			3 years	78%
Wojnar, 2009	154 treated alcoholic patients in Poland	Abstinence	1 year	52%
Polcin, 2010	245 individuals living in sober living houses	Abstinence	18 months	42%
Xie, 2010	232 dually diagnosed patients	Remission of alcohol use disorder for 6 months	10 years	86% (34% abstinence; 66% asymptomatic use)
Robinson, 2011	364 treated alcoholics	Abstinence 90 days prior to follow-up	9 months	45.6%

Lead Author of Study	Population and Sample Size	Recovery definition	Reported/ Estimated Duration of Follow-up	Recovery Rate
Schaefer, 2011	673 veterans treated for substance use disorders	Abstinence for 30 days prior to follow-up interview	6 months	51%

Appendix C

Clinical Population (Adolescents)

Abbreviations include: AOD = alcohol and other drug; IP = inpatient; OP = outpatient; SUD = substance use disorder; Tx = treatment; NA = not available in original study or paper in which study was reported, or ill-defined)

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Scopetti, 1979 (Cited in Waldron, 1997)	33	Abstinence at follow-up	NA	57%
Sells, 1979	2,745	Abstinence from opiates	4-6 years	85% abstinent from opiates
Vaglum, 1980	100	Abstinence	4-5 years	Abstinence ranged from 24% to 56% across three groups
Grenier, 1985		Current abstinence	9 months	66%
Hubbard, 1985	132 treated adolescents	Abstinence at follow-up	1 year	60%
Query, 1985	134	Abstinence	6-7 months	22%
Keskinen, 1986 (Cited in Winters, 1999)	320	Abstinence at follow-up	6 months	67% (53% no use of alcohol; 68% no use of other substances)
Harrison, 1987	915 adolescents treated in residential	Abstinence with or without brief relapse during past year	1 year	67% (44% abstinent complete year; 23% with only brief relapse)

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Feigelman, 1988	73	Abstinence since discharge	3-8 years	3%
Brown, 1989	75	Abstinence for past 6 months	6 months	30%
Friedman, 1989	330	Abstinence since discharge	6 months	Abstinence from specific substances ranging from 65-95%
Brown, 1990		Abstinence through follow-up	6 months	57% (33% abstinent; 24% improved)
Marzen,1990		Abstinence in past 12 months	5-6 years	28% of completers
Alford, 1991	157	Essentially abstinent (no use or 1-3 relapses)	6 months	71% of graduates
Griffen-Shelley, 1991	100	Abstinence at follow-up	1.5 years	35%
Hoffman, 1991	1,000	Abstinence for past year	1 year	40% abstinent for past year
Knapp, 1991	94	No alcohol or drug use	Unreported	39.4% no drug use; 33% no alcohol use.
McPeake, 1991	58	Abstinence previous 6 months	6 months	37% (73% currently abstinent)
Richter, 1991	160 treated adolescents	Abstinence	6 and 12 months	57% at 6 months (30% abstinence; 27% minor relapses); 62% at one year (36% abstinence; 26% minor relapses)
Filstead, 1992	1,127	Essentially abstinent (no use or 1 relapse)	11 months	37% abstinent; 10% with only one relapse since discharge

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Keller, 1992	19 of 275 community sample	No longer meeting diagnostic criteria for SUD	3 years	58%
Kennedy, 1993	100	Abstinence previous 3 months	3 months	62%
AARC, 1994	56	Abstinence since discharge from treatment	8-12 months	65%
Brown, 1994	142	Abstinence and asymptomatic use	6, 12, and 24 months	27% (14% abstainers and 13% non-problem users)
Stinchfield, 1994	254	Abstinence in prior 6 months	1 year	51%
AADAC, 1995	393	Abstinence for past month	3 months	27%
Bergmann, 1995	1,483	Abstinence	6 and 12 months	40% abstinent at 12 months
Brown, 1996	166	Abstinence in previous year	1-2 years	14%
Cady, 1996	234	Abstinence for prior 6 months	6 months	43%
Ralph, 1996	172	Abstinence in previous 10 months	1 year	33%
Richardson, 1996	109	Abstinence in previous 6 months	5 years	30% (plus 26% with only minor relapses)
USDHHS, 1997	236	Abstinence in previous year	1 year	30%
Hsieh, 1998	2,317 treated adolescents	Abstinence at follow-up	6 months and 1 year	52.6% at 6 months; 48.2% at 12 months

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Perkonigg, 1999	German community sample of 1,228 adolescents	Remission of cannabis abuse or dependence	1 year	41% for cannabis abuse; 31.7% for cannabis dependence
Brown, 2000	157	Abstinence	1 year	21% abstinent since discharge
Kelly, 2000	99	Abstinence	3 and 6 months	31% at 3 months and 30.3% at 6 months
Latimer, 2000	225	Continuous abstinence	1 year	14.6% alcohol abstinent; 22.2% cannabis; 28% other illicit drugs
Winters, 2000	245	Abstinence or minor relapse	6 months and 12 months	53% at 12 months (19% abstinence and 34% with minor relapse)
Brown, 2001	162	Abstinence or subclinical use	4 years	25% (7% abstainers; 8% occasional use without major relapse; 10% slow improvers); relapse followed by progressive improvement
Harrison, 2001	387 treated adolescents	Abstinence	6 months	21.4%
Maisto, 2001	131	Abstinence and use no longer meeting diagnostic criteria	1 year	51% (18.6% abstinence; 32.5% subclinical use)
Spooner, 2001	60	Abstinence and reduced use	6 months	Abstinence rates for alcohol, cannabis, opioids, and stimulants were 43%, 31%, 61%, and 83%

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Godley, 2002	114	Abstinence from cannabis and alcohol use	3 months	52% abstinence from cannabis; 50% abstinence from alcohol
Henggeler, 2002	80 treated adolescents	Abstinence from marijuana and cocaine	4 years	55% for marijuana; 53% for cocaine
Maisto, 2002	73	Abstinence and remission of DSM criteria	3 years	52% (12% abstinence; 40% reduction to non-problematic use)
Chung, 2003 Multiple Studies				
Grella	1,167	Abstinence	1 year	25%
Chung	310	Abstinence and non-problem drinking	1 year	43% (13% abstainers; 30% non-problem drinkers)
Winters	245	Abstinence or use with no symptoms	3 years	25% (4% abstinence; 21% non-problem drinking)
Abrantes		Abstinence or infrequent use	5 years	36% improvement
			8 years	46% (22% abstainers; 24% infrequent users)
Cornelius, 2003	59 adolescents completing OP treatment	Abstinence	6 months	34%
Dennis, 2004	600	Living in community with no use or AOD-related problems	1 year	Comparison of treatment conditions produced recovery rates ranging from 17-34%

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Godley, 2004	563 treated adolescents	Less than 10 days of use during 1 year follow-up	1 year	50.9% (30.3% low use in community; 20.6% moderate and decreasing use in community)
Tomlinson, 2004	126 with substance use and psychiatric disorders	Abstinence	6 months	26% in SUD-only group; 13% in SUD and Psych Disorder group
Brown, 2006		Abstinence or minor relapses	6 months and 4 years	27% abstinent; 30% minor AOD use 6% abstinent at all follow-up points over 4 years
Winters, 2007	159	No substance dependence diagnosis at follow-up (could have substance abuse diagnosis)	1, 4, and 5.5. years	42.8% (6% abstinence)
Larm, 2008	2,088 treated adolescents	No long-term substance-related adverse consequences in adulthood	15 years and 30 years	20%
Chi, 2009	357 treated adolescents	Abstinence from alcohol and drugs in previous 30 days	3 years	30%
de Dios, 2009	1,179	Abstinence	12 months	32-33%
Sterling, 2009	296 treated adolescents	Abstinence from both alcohol and drugs	3 years	29.7% abstinence from both alcohol and drugs

Lead Author of Study	Sample Size	Definition of Recovery/ Remission	Length of follow-up	Recovery/Remission Rate
Anderson, 2010	153 treated adolescents followed into adulthood	Abstinence	10 years	28.7%

Reminder on Recovery Rate Calculations: In reviewing the data in Appendices A, B, and C, the reader is reminded that the definitions of remission, recovery, abstinence, improvement, etc. varied considerably across the studies profiled, as did the method through which the rates were calculated. Where they were present, I have reported the rates as they were presented in the original study. Where no rate was reported but a rate could be extrapolated, I calculated the rate with the available data. While averages reported for all studies are helpful in measuring as best we can the prevalence of recovery and rates of recovery, it is not possible to compare rates across studies due to these differences in definition and method of measurement.



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: Betty Ford Institue Consensus Panel (2013). The Status and Future of Addiction Recovery Support Services in the United States. Posted at **www.williamwhitepapers.com**

The Status and Future of Addiction Recovery Support Services in the United States

William White, MA[a] ; Keith Humphreys, PhD[b] ; Monique Bourgeois, M.A[c]; Page Chiapella, PhD[d] ; Arthur Evans, PhD[e] ; Michael Flaherty, PhD[f] ; Peter Gaumond, PhD[g]; Patrick Haggerson, M.A.[h] ; Beverley Haberle, M.H.S[i] ; Tom Hill, M.S.W.[j] ; Lee Ann Kaskutas, PhD[k] ; John Kelly, PhD[l] ; Carol McDaid[m] ; Joe Powell, L.D.C.[n] ; Christy Scott, Ph.D.[o]; Pat Taylor, M.S.W.[j]

[a] *Chestnut Health Systems, Bloomington, IL*
[b] *Veterans Affairs and Stanford University Medical Centers, Palo Alto, CA*
[c] *Association of Recovery Schools, Richmond, MN*
[d] *National Institute on Alcohol Abuse and Alcoholism, Bethesda, MD*
[e] *Philadelphia Department of Behavioral Health, Philadelphia, PA;*
[f] *Institute for Research, Education and Training in the Addictions, Jamison, PA;*
[g] *Office of National Drug Control Policy, Gaithersburg, MD;*
[h] *Betty Ford Institute, Palm Desert, CA*
[i] *The Council of Southeast Pennsylvania, Jamison, PA*
[j] *Faces & Voices of Recovery, Washington, DC*
[k] Alcohol *Research Group (ARG), Emeryville, CA*
[l] *Harvard Center for Addiction Medicine, Boston, MA*
[m] *Capitol Decisions, Washington, DC*
[n] *Associations of Persons Affected by Addiction, Dallas, TX*
[o] *Chestnut Health Systems, Chicago, IL*

Authors Note: Any opinions expressed in this paper do not necessarily reflect the official policy positions of government agencies that employ or are advised by the authors. Address correspondence to: Keith Humphreys, PhD, Department of Psychiatry, 401 N. Quarry Road (MC: 5717), Stanford University School of Medicine, Stanford, CA 94305-5717. FAX (650) 617-2736.

Abstract

Addiction recovery support services (RSS), including recovery housing, schools, coaches, ministries, and community centers, are rapidly spreading in the United States. In February 2012, the Betty Ford Institute and the University of California, Los Angeles, convened an expert consensus conference to address four questions related to the growing RSS phenomenon: (1) What is new in the delivery of RSS in the United States?

(2) What is known about RSS from the standpoint of science, practice, and experience? (3) What does the addiction treatment and recovery field need to know about RSS? (4) What are the next steps needed to develop, refine, and evaluate RSS? This article summarizes the expert panel's findings and recommendations.

Keywords: peer support, recovery, mutual aid, recovery support services, consensus conference

Introduction

Recovery from addiction is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship (Betty Ford Institute Consensus Panel, 2007). Historically, specialized support for recovery from alcohol and other drug addictions in the United States has been provided by peer-led mutual-aid organizations and professionally led addiction treatment organizations. The former include Native American abstinence-based religious/cultural revitalization and healing movements, 19th century recovery societies (e.g., Washingtonians, recovery-focused fraternal temperance societies, ribbon reform clubs, Keeley Leagues), Alcoholics Anonymous (AA) and its 12-step offshoots (e.g., Narcotics Anonymous, Cocaine Anonymous), mutual help organizations that reject any AA-style spiritual content (e.g., SMART Recovery) and, conversely, others (e.g., Celebrate Recovery) that forgo AA's generic "higher power" concept to instead employ an explicitly religious approach (Kelly & White, 2012). The latter span early inebriate homes and asylums, private addiction cure institutes, bottled and boxed home cures, and the late 20th century evolution of today's addiction treatment system in which evidence-based practices play an increasing role (White, 1998).

In the past two decades, a type of addiction recovery support has emerged that does not fit perfectly in either the category of peer-led recovery organizations or professional addiction treatment. This service form encompasses new social settings (e.g., recovery community organizations, recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries) and service roles (variably called recovery coaches/guides/mentors, recovery support specialists, or peer support specialists; Cousins, Antonini & Rawson, 2012; White, 2008, 2009; White, Kelly, & Roth, 2012).

The development of such "recovery support services" (RSS) raises numerous questions, opportunities, and challenges for the field. Accordingly, in February of 2012, the Betty Ford Institute (BFI), in collaboration with the University of California, Los Angeles (UCLA), hosted a consensus conference to explore the history, status, and future of recovery support services in the United States. Discussions were organized around four broad questions:

1) What is new in the delivery of recovery support services (RSS) in the United States?
2) What is known about RSS from the standpoint of science, practice, and experience?
3) What does the addiction treatment/recovery field need to know about RSS?
4) What are the next steps needed to develop, refine, and evaluate RSS?

This article summarizes the conclusions drawn from the BFI/UCLA Consensus Conference and briefly discusses the potential historical significance of RSS.

Several important historical trends set the stage for the 2012 BFI/UCLA Consensus Conference. These include the growth and diversification of addiction recovery experiences across and within secular, spiritual, and religious addiction recovery mutual-aid groups in the United States during the second half of the 20th century (Humphreys, 2004; White & Kurtz, 2006), the perceived disconnection between addiction treatment and the larger and more

enduring process of long-term addiction recovery (Elise, 1999; Morgan, 1994), the emergence of a new grassroots recovery advocacy movement in the United States (White, 2007b), and the rise and maturation of recovery community organizations (RCOs) organized by and on behalf of people in recovery, whose missions include policy advocacy and the delivery of peer-based recovery support services (Valentine, 2011; White, 2009, 2010).

Also influencing the emergence of RSS are the reconceptualization of addiction as a chronic medical disorder (Dennis & Scott, 2007; Flaherty, 2006; McLellan, 2002; McLellan, Lewis, O'Brien, & Kleber, 2000), the clearer articulation of the stages of long-term personal and family recovery (Brown & Lewis, 1999; Dennis, Scott, Funk, & Foss, 2005), calls to extend addiction treatment from models of acute biopsychosocial stabilization to models of sustained recovery management (Flaherty, 2006; Humphreys & Tucker, 2002), efforts to nest recovery management approaches within larger recovery-oriented systems of care (ROSC; Kelly & White, 2011; White, 2007a, 2008), and the promotion of RSS within and entirely outside of the formal health care system (Achara-Abrahams, Evans, & King, 2011; Clark, 2008; Kaplan, 2008; Kirk, 2011; Valentine, 2011). A further recent contextual influence is the expectation that services for alcohol and other drug problems, including RSS, will be expanded and integrated into other community service institutions as an outcome of the Affordable Care Act of 2010 (Buck, 2011; Hill, McDaid, & Taylor, 2012).

Seen as a whole, these trends reflect an increasing momentum toward the adoption of a recovery paradigm as a central organizing construct for the addictions field and the integration of RSS as part of larger transformation efforts within recovery-focused systems of care in the United States and in the United Kingdom (Berridge, 2012; El-Guebaly, 2012; White, 2005, 2008). These trends also suggest the need for a recovery research agenda to guide this re-orientation of the field's conceptual foundation and service practices (Laudet, Flaherty, & Langer, 2009; Laudet & Humphreys, 2012).

The Consensus Process

The Betty Ford Institute (BFI)—the prevention, education, and research arm of the Betty Ford Center—has for the past 7 years hosted a series of consensus conferences aimed toward the goals of defining recovery (Betty Institute Consensus Panel, 2007, McLellan, 2010), extending the benefits of addiction treatment through innovative continuing care strategies, (McKay et al., 2009), enhancing graduate medical school education in addiction (O'Connor, Nyquist, & McLellan, 2011), and breaking the intergenerational cycle of addiction through parent-focused strategies.

A total of 30 individuals participated in the RSS Consensus Conference convened in February 2012 at the Betty Ford Center in Rancho Mirage, California. The purpose of the conference was to discuss the status and future of RSS within the addictions field. Those present included a moderator, four speakers, three policy experts, seven community content experts (including representatives from recovery community organizations), three addiction research experts, and 15 observers. The policy experts included representatives from the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Office of National Drug Control Policy.

The consensus process involved the presentation of papers on the history of RSS (White, 2012), the current RSS landscape (Hill et al., 2012), and research to date on RSS (Laudet & Humphreys, 2012); a facilitated discussion of the four guiding questions outlined above; and identification of points of group consensus and recommendations. To avoid premature consensus, the facilitator and participants put special emphasis on drawing out disagreements and difficult issues.

Following the conference, participants were asked to complete an online survey rating their top RSS priorities

drawn from the recommendations generated at the conference. Results were tabulated and are presented in the present article.

Results

There was clear consensus on the most significant aspects of RSS as they are developing in the United States. First, RSS rest on the premise that efforts to facilitate recovery from addiction should be grounded in an understanding of the chronicity and complexity of such disorders. A given RSS might be delivered in tandem with treatment, mutual aid organizations, or both of these entities, or it might be delivered independently. As a class of intervention, however, RSS are organized to offer longer-term support than that provided by acute care addiction treatment as well as a broader range of support than that provided by either recovery mutual-aid organizations or addiction treatment programs.

Second, RSS are distinctive in their frequent delivery within new recovery-focused entities (recovery community organizations, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes) and within such varied community settings as jails, schools, and Federally Qualified Health Centers. Rather than exclusively ask, "How do we get the person in need to a treatment center or mutual aid meeting?" RSS providers ask, "How do we deliver nested recovery support within the settings where he or she is already involved?" As this conceptualization suggests, the formal treatment system is only one of many venues through which RSS are provided.

Third, those providing RSS extol the legitimacy of multiple long-term pathways of recovery and value personal choice in the recovery process. This distinguishes them from mutual help organizations that facilitate travel down a single pathway to recovery (i.e., the pathway of that particular fellowship). RSS include assertive linkage to a broad spectrum of recovery mutual aid and treatment options, provide a larger menu of recovery support options, and utilize recovery-focused service planning protocols quite different from traditional treatment planning schema (Borkman, 1997).

Fourth, involvement of persons in recovery is common in the development and delivery of RSS (White, 2009). At the same time, individuals who have not personally experienced addiction are also often involved in RSS.

Fifth, RSS are distinctive in offering support across the stages of recovery—spanning pre-recovery engagement and recovery priming, recovery initiation and stabilization, recovery maintenance, enhanced quality of personal and family life in long-term recovery, and support in breaking intergenerational cycles of problem transmission. Also of note is that RSS can be provided before, after, or in tandem with professional treatment, or in lieu of such treatment. Prior or concurrent treatment is rarely a requirement for participation in RSS.

Other distinguishing aspects of RSS noted in the consensus panel discussions include the more assertive style of RSS (compared to most recovery mutual aid or professional treatment initiatives), the greater emphasis on advocacy as a critical dimension of RSS, the extensive use of volunteers—particularly peers—in the delivery of RSS, the differences in ethical guidelines for RSS compared to those for addiction counselors, and a focus on the community as an object of change as well as the individual and family (White, 2012).

In reviewing existing RSS trends and RSS-related research, the consensus panel drew five major conclusions.

1) RSS have been implemented in a wide variety of organizational and community settings (Hill et al., 2012). Further, RSS have been tailored to the needs of special populations (including support for those in medication-assisted recovery from opioid addiction), adapted across diverse cultural and linguistic contexts, and often provided in gender-based settings.
2) Experience confirms that there is demand for RSS. Individuals and

families in all stages of recovery are seeking and using such services in tandem with, and in lieu of, professional treatment and mutual help organizations.

3) Recovery community organizations (RCOs) and other organizations are identifying critical aspects of the implementation of RSS, e.g., methods of recruiting, screening, training, and supervising RSS providers.
4) The proliferation of RSS in the United States and the United Kingdom is far ahead of the research directly evaluating the short- and long-term effects of such services (Laudet & Humphreys, 2012.) Nevertheless, the theoretical rationale for RSS is buttressed by research showing the positive influence of social support on short- and long-term recovery outcomes (Beattie & Longabaugh, 1999; Groh, Jason, Davis, Olson, & Ferrari, 2007; Humphreys, Mankowski, Moos, & Finney, 1999; Humphreys, Moos, & Cohen, 1997; Stout, Kelly, Magill & Pagano, 2012), comparisons of social versus medical model programs (Kaskutas, Witbrodt, & French, 2004; Kaskutas, Zavala, Parthasarathy, & Witbrodt, 2008), and studies evaluating assertive approaches to recovery checkups and continuing care for adults (Dennis & Scott, 2012; McKay, 2005, 2009; Scott & Dennis, 2009; Scott, Dennis, & Foss, 2005) and adolescents (Godley, Godley, Dennis, Funk, & Passetti, 2007).
5) Research in some RSS arenas is quite strong (e.g., recovery housing; Jason & Ferrari, 2010; Jason et al., 2007; Polcin, Korcha, Bond, & Galloway, 2010). For others, the research base is descriptive (e.g., recovery schools and collegiate recovery communities; Cleveland, Harris, Baker, Herbert, & Dean, 2007; Harris, Baker, Kimball, & Shumway, 2008; Moberg & Finch, 2008) or non-existent (e.g., recovery community centers, recovery-focused work programs, recovery ministries, and recovery cafés). Especially troubling is the paucity of research on RSS specialty roles (e.g., recovery coaches), given their rapid proliferation across the United States as a component of efforts to embrace models of recovery management and recovery-oriented systems of care. More positively, administrative data gathered on high-profile national initiatives, such as the Substance Abuse and Mental Health Services Administration's Recovery Community Services Program and Access to Recovery, suggest positive effects of RSS on recovery outcomes (e.g., sobriety/remission, improvements in global health, community reintegration; Laudet & Humphreys, 2012; White, 2009).

Consensus conference discussions of an RSS research agenda focused, in order of perceived priority, on the need to (1) assess the effectiveness and cost-effectiveness of particular types of RSS in producing outcomes in individuals and families, within treatment systems, within local communities of recovery, and within communities more broadly; (2) gather and synthesize practice-based evidence and wisdom related to the optimal design and delivery of RSS; (3) conduct surveys that quantify the magnitude and methods being used to deliver RSS in the United States; (4) identify active ingredients of RSS and particular service combinations and sequences that most strongly influence recovery outcomes; and (5) create and validate instruments to assess individual and family needs for particular types of RSS. Some of the more specific questions posed within this discussion are presented in Table 1.

Table 1: What we need to know about Recovery Support Services (RSS)

Assessing the effectiveness and cost-effectiveness of RSS	What are key elements of recovery that would lend themselves to measurement as RSS outcomes (e.g., sense of self-efficacy, quality of life, recovery/social capital, etc.)? Are there differences in outcomes influenced by the recovery status of the person delivering RSS or by the organizational setting through which RSS are delivered? Does the duration and amount of contact influence the effectiveness of RSS? Do RSS avert or reduce use of costly acute care services (e.g., emergency rooms)? What existing measures might be adopted to measure some or all identified elements?
Optimal design for RSS	What is a typical menu of RSS? How do RSS coming out of RCOs and treatment organizations differ from each other, if at all, and from those being offered by the life coaching field? What are the key quality indicators of RSS? What qualifications are required to deliver RSS? How does personal or family recovery by providers affect delivery of RSS? Does the impact of RSS vary depending on whether staff are volunteers, paid, or a combination of such, or in recovery, not in recovery, or a combination? How are RSS being refined across boundaries of age, gender, culture, drug choice, and pathways of recovery? Is there an optimal length or intensity of service that RSS should provide? How many people can a single RSS provider serve simultaneously in different contexts and with different populations? How can people providing RSS be best supervised? How can RSS avoid becoming either a cheap form of treatment and a rationale for cutting treatment services, or, becoming commercialized to the point that they lose their grassroots nature and commitment to advocacy that make them appealing to those who access them ?

	What are the critical considerations in developing new RSS and new RSS service locations?
National, state, and local assessment of currently available RSS	What is the present national, state, and local availability of RSS? What is the current need/demand for particular types of RSS? What is the RSS needs profile of people at different stages of recovery? How is technology being utilized in the delivery of RSS?
Active ingredients/combinations of RSS	What are the most potent ingredients of RSS in terms of their influence on recovery outcomes? Which individuals are most likely to benefit from RSS? Are there particularly potent RSS combinations or sequences? Do these combinations or sequences need to be implemented during certain "critical" recovery phases to be effective? Are there ingredients unique to RSS that are not found in recovery mutual aid or professional addiction treatment?
Assessing individual and family need for RSS	Who is most likely to need and utilize RSS? How are organizations delivering RSS evaluating the support needs and service response of those they serve, e.g., individual and community needs assessments, tools, checklists, recovery planning formats? Is there a needs-and-strengths profile of people at different stages of recovery? If not, could it be developed?

The closing discussion of the RSS Consensus Conference generated an action agenda for RSS service providers, policymakers and administrators, and the research community. Table 2 displays the specific recommendations within these three arenas.

Table 2: Recommended and Prioritized Next Steps in the Evolution of RSS

For the RSS practice community	Clarify role boundaries between RSS provider, addiction counselor, life coach, and other service roles (e.g., case managers, outreach workers) and the relationship between RSS, recovery mutual aid organizations, and professional addiction treatment.

	Communicate to multiple stakeholders the precise purpose of RSS and their role in the larger service/support system and in the broader community. Survey RCOs, treatment providers, Access to Recovery sites, and Single State Agencies to establish a benchmark of current RSS practices. Create a central repository of documents, tools, media, etc., that can be used to enhance replication of RSS. Disseminate documents that can help educate policymakers, funders, treatment and allied service professionals, and the recovery community about the nature of RSS and evaluation results.
Policymakers and administrators	Integrate RSS within the implementation of the Affordable Care Act. Integrate questions related to RSS in national surveys of recovery prevalence and addiction treatment. Provide technical assistance and support to enhance the mobilization of local recovery communities and development of local recovering community organization RSS capabilities. Host and participate in conferences that include an overview of federal RSS initiatives, local RCO activities related to RSS, and what private managed behavioral health companies and disease management programs are doing with RSS. Evaluate states' Medicaid experiences with RSS and disseminate the findings
Researchers	Pursue quantitative and qualitative outcome studies of RSS. Develop a valid and reliable measure of recovery Use existing data sets to assess the potential need/market for RSS. Design new research in light of findings of prior studies (e.g. Kaskutas et al., 2004). Develop standard evaluation protocols for use by organizations delivering RSS. Create opportunities for dialogue between addiction researchers and representatives from recovery community organizations involved in RSS delivery. Examine comparable RSS for other health conditions for their effectiveness and transferability to addiction RSS

Discussion

The BFI/UCLA Consensus Conference review of current research and prevailing practices related to recovery support services drew five broad conclusions.

1. RSS are being implemented in diverse geographical, cultural, and organizational settings for people seeking recovery from addiction, those newly in recovery, and those in long-term recovery. Some people access RSS in combination with addiction treatment programs and mutual help organizations, whereas others do so entirely independent of these services.
2. Payers, providers, and the recovery community are showing increasing interest in RSS as a way to support recovery from addiction.
3. Although the development of RSS has strong theoretical support, rigorous research has been limited to particular recovery support institutions (e.g., recovery residences) and to particular recovery support protocols (e.g., posttreatment recovery management checkups).
4. The expansion of existing RSS, replication of RSS in new settings, and development of new RSS need to be informed by studies evaluating the effects of a wide variety of RSS components on short- and long-term recovery outcomes for individuals and families, and studies that contribute to the development of RSS practice guidelines and standards. At the same time, the practice of RSS cannot wait to proceed until traditional academic research projects are completed. Researchers and providers should gather, synthesize, and attend to practice-based evidence, rather than assuming that traditional research approaches can be the only guide to action.
5. The further development, evaluation, and refinement of RSS in the United States will require concerted action by the RSS practice community, policymakers, systems administrators, and the research community.

There are a number of important ways in which RSS models being replicated in U.S. communities could expand support for individuals recovering from addiction. RSS providers, such as recovery mutual-aid groups, frequently draw on the rich experiential knowledge and expertise of individuals in recovery (Borkman, 1976; Jackson, 2001). RSS could provide a menu of support services to a broad spectrum of individuals (including those without past or current treatment involvement) for an extended period of time (including pre-recovery engagement and long-term personal or family recovery). RSS can expand access to services and supports because they are delivered primarily within the natural environments of those receiving them (homes, neighborhoods, schools, churches, hospitals, jails). Another distinctive feature about RSS is that they strive for change not just in individuals but in the community. Specifically, RSS attempt to develop community recovery capital—the physical, psychological, and social space within the community where recovery can flourish (Granfield & Cloud, 1999; Humphreys et al., 1997). This focus on community goes well beyond the traditional clinical perspective of changing individuals (or, at most, individuals and their immediate family) and reflects the advocacy component of RSS.

RSS serve individuals who are on diverse pathways of recovery, including persons who initiate and sustain recovery without involvement in a mutual aid group. The RSS provider must therefore become knowledgeable and fluent across multiple pathways and styles of recovery initiation and maintenance, including working with persons with lower problem severity/complexity. RSS also address issues beyond initiation and maintenance of recovery, e.g., housing, education, employment, debt management, criminal

record expungement, physical and mental health, exercise and nutrition, social networking, community service, advocacy opportunities, and recovery-linked involvement in art, literature, music, theatre, or sports.

RSS represent a new menu of recovery support mechanisms delivered in natural community environments through novel social institutions (e.g., recovery community organizations [RCOs]) and innovative service roles (e.g., recovery coach). The RCO is distinct from treatment organizations and recovery mutual-aid groups, and the recovery coach fits neither the categories of addiction counselor nor recovery mutual-aid sponsor/mentor. The critical question regarding the ideal means of resolving alcohol and other drug problems is not, "Should people seeking recovery choose professional treatment or a recovery mutual-aid group or RSS?" It is rather, "Are there ways that professional treatment, recovery mutual-aid societies, and RSS can be created and organized such that more numerous and more diverse long-term recovery pathways are available to more people?" Natural community experiments and controlled trials are needed to discover, for the treatment of addiction, what combined, sequenced, and stand-alone interventions have discovered for the treatment of AIDS and cancer. The advent of RSS creates an historic opportunity for such discoveries, though considerable challenges lie ahead in more clearly defining and more rigorously evaluating this expanding menu of services delivered through new roles and in new service settings.

Acknowledgment: The 2012 BFI/UCLA Consensus Conference on Recovery Support Services was financially supported by Norlien Foundation, Hilton Foundation, and American Legacy Foundation (Legacy for Health). We thank Richard A. Rawson and Wilson Compton for very helpful critiques of these ideas. The RSS Consensus Conference was facilitated by Keith Humphreys, with Sarah J. Cousins and Kristi Wellenberger serving as recorders.

References

Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187–208). New York: Springer Science.

Beattie, M. C., & Longabaugh, R. (1999). General and alcohol-specific social support following treatment. *Addictive Behaviors*, *24*, 593–606.

Berridge, V. (2012). The art of medicine: The rise, fall, and revival of recovery in drug policy. *Lancet*, *379*, 22–23.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221–228.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*, 443–456.

Borkman, T. J. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment, 15*(1), 37–42.

Brown, S., & Lewis, B. (1999). *The alcoholic family in recovery: A developmental model*. New York: Guilford.

Buck, J. A. (2011). The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Affairs*, *30*(8), 1402–1410.

Clark, W. (2008). *Recovery-oriented systems of care: SAMHSA/CSAT's public health approach to substance use problems & disorders. Aligning concepts, practice, and contexts to promote long term recovery: An action plan*. Philadelphia, PA: Institute for Research, Education & Training in Addictions (IRETA).

Cleveland, H. H., Harris, K. S., Baker, A. K.,

Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment*, *33*(1), 13–23.

Cousins, S. J., Antonini, V. P., & Rawson, R. A. (2012). Utilization, measurement, and funding of recovery support services. *Journal of Psychoactive Drugs, 44* (4), 325–333.

Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45–55.

Dennis, M. L., & Scott, C. K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence, 121*(1–2), 10–7.

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*, S51–S62.

El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine, 6*(1), 1–9.

Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery, 6*(2), 11–23.

Flaherty, M. (2006). *Special Report: A unified vision for the prevention and management of substance use disorders: Building resiliency, wellness and recovery – A shift from an acute care to a sustained care recovery management model*. Pittsburgh, PA.: Institute for Research, Education & Training in Addictions (IRETA).

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). 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.

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

Groh, D. R., Jason, L. A., Davis, M. I., Olson, B. D., & Ferrari, J. R. (2007). Friends, family, and alcohol abuse: An examination of general and alcohol-specific social support. *The American Journal on Addictions*, *16*, 49–55.

Harris, K., Baker, A., Kimball, T., & Shumway, S. (2008). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction and Recovery, 2*(2–4), 220–237.

Hill, T., McDaid, C., & Taylor, P. (2012, February). *Peer recovery support services: Evolving community-based practices and infrastructure*. Presented at the 2012 Betty Ford Institute/UCLA annual recovery conference, February 21–23, Rancho Mirage, CA.

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

Humphreys, K., Mankowski, E., Moos, R. H., & Finney, J. W. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance use? *Annals of Behavioral Medicine, 21*(1), 54–60.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231–238.

Humphreys, K., & Tucker, J. (2002). Towards more responsive and effective intervention systems for alcohol-related problems. *Addiction, 97*, 126–132.

Jackson, S. W. (2001). The wounded healer. *Bulletin of the History of Medicine*, *75*, 1–36.

Jason, L. A., & Ferrari, J. R. (2010). Oxford House recovery homes:

Characteristics and effectiveness. *Psychological Services,7*(2), 92–102.

Jason, L. A., Olson, B. D., Ferrari, J. R., Majer, J. M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction, 102*(7), 1114–1121.

Kaplan, L. (2008). *The role of recovery support services in recovery-oriented systems of care* (DHHS Publication No. (SMA) 08-4315). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Kaskutas, L. A., Witbrodt, J., & French, M. T. (2004). Outcomes and costs of day hospital treatment and nonmedical day treatment for chemical dependency. *Journal of Studies of Alcohol, 65*(3), 371–382.

Kaskutas, L. A., Zavala, S. K., Parthasarathy, S., & Witbrodt, J. (2008). Costs of day hospital and community residential chemical dependency treatment. *Journal of Mental Health Policy Economics,* 11(1), 27–32.

Kelly, J. F., & White, W. L. (Eds.) (2011). *Addiction recovery management: Theory, science and practice.* New York: Springer Science.

Kelly, J. F., & White, W. L. (2012). Broadening the base of addiction mutual help. *Journal of Groups in Addiction Recovery, 7*, (2–4), 82–101.

Kirk, T. (2011). Connecticut's journey to a statewide recovery-oriented health-care system: Strategies, successes, and challenges. In J. F. Kelly, & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 209–235). New York: Springer Humana Press.

Laudet, A., Flaherty, M., & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.

Laudet, A. B., & Humphreys, K. (2012, February). *Promoting recovery in an evolving context: What we know and what we need to know about recovery support services.* Presented at the 2012 BFI/UCLA annual recovery conference, February 21–23, Rancho Mirage, CA.

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction*, *100*(11), 1594–1610.

McKay, J. R. (2009). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment, 36*(2), 131–145.

McKay, J. R., Carise, D., Dennis, M. L., Dupont, R., Humphreys, K., Kemp, J.,…Schwartzlose, J. (2009). Extending the benefits of addiction treatment: Practical strategies for continuing care and recovery. *Journal of Substance Abuse Treatment*, *36*, 127–130.

McLellan, A. T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, *97*(3), 249–252.

McLellan, A. T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition: The Betty Ford Consensus Panel and consultants. *Journal of Substance Abuse Treatment*, *38*, 200–201.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689–1695.

Moberg, D. P., & Finch, A. J. (2008). Recovery high schools: A descriptive study of school programs and students. *Journal of Groups in Addiction and Recovery, 2*, 128–161.

Morgan, O. J. (1994). Extended length of sobriety: The missing variable. *Alcoholism Treatment Quarterly*, *12*(1), 59–71.

O'Connor, P. G., Nyquist, J. G., & McLellan, A. T. (2011). Integrating addiction medicine into graduate medical education in primary care: The time has come. *Annals of Internal Medicine*, *154*(1), 56–60.

Polcin, D. L., Korcha, R. A., Bond, J., & Galloway, G. (2010). Sober living houses for alcohol and drug dependence: 18-month outcomes. *Journal of Substance Abuse Treatment, 38*(4), 356–365.

Scott, C. K., & Dennis, M. L. (2009). Results from two randomized clinical trials evaluating the impact of quarterly recovery management checkups with adult chronic substance users. *Addiction, 104*(6), 959–971.

Scott, C. K., Dennis, M. L., & Foss, M. A. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment re-entry, and recovery. *Drug and Alcohol Dependence*, *78*, 325–338.

Stout, R. L., Kelly, J. F., Magill, M., & Pagano, M. E. (2012) Association between social influences and drinking outcomes across three years. *Journal of Studies on Alcohol and Drugs, 73*(3), 489–497.

Valentine, P. (2011). Peer-based recovery support services within a recovery community organization: The CCAR experience. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 259–279). New York: Springer Science.

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 3–15.

White, W. L. (2007a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. *(Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright).* Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. L. (2007b). The new recovery advocacy movement in America. *Addiction, 102,* 696–703.

White, W. L. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12–13), 1987–2000.

White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L. (2010). Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls. *Alcoholism Treatment Quarterly, 28*, 256–272.

White, W. L. (2012, February). *Historical perspectives on addiction recovery support*. Presented at the 2012 BFI/UCLA annual recovery conference, February 21–23, Rancho Mirage, CA.

White, W., Kelly, J., & Roth, J. (2012). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, 7(2–4), 297–317.

White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1–2), 21–61.



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**

Chronology of the Addiction Recovery Advocacy Movement

Pat Taylor, Tom Hill and William White

We've described the rich history of people in recovery, family members, friends and allies coming together to support recovery by highlighting key moments from the 1700s leading up to the present day. Please join us in acknowledging the shoulders we stand on and in forging a movement that embraces recovery as a civil right for all Americans and people all across the world.

Earlier Organizing Efforts

1730s-1830s Abstinence-based, Native American religious and cultural revitalization movements mark the first recovery focused advocacy efforts in North America.

1799 Prophet-led Recovery Movements: Handsome Lake (1799), Shawnee Prophet (Tenskwatawa, 1805), Kickapoo Prophet (Kennekuk, 1830s)

1840s The Washingtonian movement marks the first Euro-American movement organized by and for those recovering from alcoholism—a movement that involved a public pledge of sobriety and public acknowledgement of one's recovery status.

1840s Conflict within Washingtonian societies rises over the question of legal prohibition of the sale of alcohol and the role of religion in recovery; recovering alcoholics go underground in following decades within fraternal temperance societies and ribbon reform clubs.

1845 Frederick Douglass acknowledges past intemperance, signs temperance pledge and becomes central figure in "Colored Temperance Movement"—framing sobriety as essential for full achievement of citizenship.

1895 Keeley League members (patient alumni association of the Keeley Institutes—a national network of addiction cure institutes) march on the Pennsylvania capital in support of a Keeley Law that would provide state funds for people who could not afford the Keeley cure.

1906 Current and former patients of the Massachusetts Hospital for Dipsomaniacs and Inebriates organize and level charges of medical incompetence and patient abuse and neglect against the institution.

1906-
1940s Recovering alcoholics champion "lay therapy" approach to alcoholism treatment, with some working in first interdisciplinary alcoholism treatment teams.

1942 Anderson, D. (Dwight) Alcohol and Public Opinion. *Quarterly Journal of Studies on Alcohol*, 3(3):376-392 Anderson presents his "kinetic ideas": "1. That the problem drinker is a sick man, exceptionally reactive to Alcohol, 2. That he can be helped. 3. That he is worth helping. 4. That the problem is therefore a responsibility of the healing professions, as well as of the established health authorities and the public generally."

1944 Mrs. Marty Mann founds the National Committee for Education on Alcoholism which will evolve into the National Council on Alcoholism and today's National Council on Alcoholism and Drug Dependence (NCADD). In Formation of a National Committee for Education on Alcoholism, *Quarterly Journal of Studies on Alcohol*, 5(2):354. Mann outlines the five ideas that will be at its core: "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."

1956 Hospitalization of Patients with Alcoholism. (1956). *Journal of the American Medical Association*, October 20. AMA resolution on admitting alcoholics to general hospitals does not explicitly state that alcoholism is a disease but does refer to the alcoholic as a "sick individual": the acknowledgment (resolution) of alcoholism as a disease will not pass until 1967. The 1956 resolution states: "Hospitals should be urged to consider admission of such patients with a diagnosis of alcoholism based upon the condition of the individual patient, rather than a general objection to all such patients."

1958 The Association of Halfway House Alcoholism Programs of North America (AHHAP) founded.

1967 The American Medical Association passes a resolution that "alcoholism is a disease that merits the serious concern of all members of the health professions."

1969 US Senator Harold Hughes (D-Iowa), a self-described recovered alcoholic, chairs Congressional hearing that led to passage of the 1970 Comprehensive Alcoholism Prevention and Treatment Act. Witnesses testifying include AA co-founder Bill Wilson and Mrs. Marty Mann of the National Council on Alcoholism.

1973 The Committee of Concerned Methadone Patients and Friends, Inc. founded.

1975 The first Oxford House is opened in Silver Spring, Maryland; Oxford Houses grow exponentially under the leadership of Paul Molloy.

1976 Thomasina Borkman publishes classic article calling for legitimacy of experiential knowledge within the alcohol and other drug problems arena (Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*, 443-456.)

1976 The National Council on Alcoholism launches Operation Understanding, where 52 prominent Americans publicly proclaimed their status as people in long-term recovery from alcoholism.

1977 Campus-based recovery support services begin at Brown University (1977) and Rutgers University (1983).

1978 Former President Gerald Ford and First Lady Betty Ford announce to the nation that Mrs. Ford has been treated for and is in recovery from addiction to alcohol and other drugs.

1979 Phoenix Schools, the first recovery high school in the U.S., opens in Montgomery County, MD.

1980s A new generation of social model recovery support programs emerges in California that focus on recovery for individuals, families and communities; early beginnings of extension of recovery support for individuals to creating recovery conducive community environments (Borkman, T.J., Kaskutas, L.A., Room, J., Bryan, K. & Barrow, D. (1998). An historical and developmental analysis of social model programs. *Journal of Substance Abuse Treatment*, 15(1), 7-17.)

1985 Improbable Players (www.improbableplayers.org) founded by Lynn Bratley.

1986 Texas Tech University develops collegiate recovery program, leading to the Center for the Study of Addiction and Recovery under the leadership of Kitty Harris, PhD.

1987 Augsburg College begins StepUP Program—a widely emulated campus recovery program.

1988 The National Alliance of Methadone Advocates (NAMA) founded. (In 2009, its name is changed to National Alliance for Medication Assisted Recovery [NAMA-R] in order to include all medications that treat addictions.)

1991 Former Senator Harold Hughes founds the Society of American for Recovery (SOAR). SOAR dissolved in late 1994-early 1995.

> *The Society of Americans for Recovery is a grass-roots organization of concerned people from all walks of life. It is dedicated to the fundamental belief that alcoholic and drug-dependent people and their families should have the same rights and privileges as all other people…It strives for a better understanding that treatment and recovery will reduce other health, social, and economic problems.*

1991 Massachusetts Organization of Americans for Recovery founded as a chapter of SOAR; (In 1998, rechristened and renewed as Massachusetts Organization for Addiction Recovery--MOAR.)

1991 Friends of Recovery Association founded to help establish Oxford Houses in Kansas.

1993 The Stepping Stones Accords reached under Phyllis Mulaney's leadership.

> *Principles In Common for THE NATIONAL FORUM*

Stepping Stones Accord: Discovering Solutions to the Nation's Alcohol and Other Drug Problems

Alcohol and other drug addiction remains America's number one health problem and major tax burden, undermining the general health and welfare of its citizens and eroding its economy. A solution requires wide knowledge and broad acceptance of responsibility by every segment of society. To build such a focus, the National Forum participants commend these accords:

1. To fight for a comprehensive range of quality prevention, treatment, and recovery services for chemical dependency, a primary disease in the nation's healthcare system.
2. To incorporate cultural and age appropriate care for family members whether or not the addicted person is in treatment and/or recovery.
3. To acknowledge major advances in science and practice that ensures more effective approaches to treatments, prevention, and public policy and bring the possibility of recovery to more and more Americans.
4. To focus our message to the public, communicating pride in our accomplishments, acknowledging our limitations and instilling hope for science and practical solutions to addiction disease in the future.
5. To engage our organizations in the ongoing healthcare debate, committing resources and special skills in keeping with these accords.

1994 Morgan, O. J. (1994). Extended length of sobriety: The missing variable. *Alcoholism Treatment Quarterly*, 12(1), 59-71. Calls attention to growing disconnection between addiction treatment and the larger and more enduring process of long-term addiction recovery.

1996 The Johnson Institute was founded in Minnesota and headed by George Bloom to emphasize early intervention, family involvement and community support. Bloom founded The National Forum to build on the Stepping Stones Accord. National Forum leaders included Paul Samuels, Legal Action Center; Paul Wood, National Council on Alcoholism and Drug Dependence; Sis Wenger, National Association for Children of Alcoholics; Bill Butynski, National Association of State Alcohol and Drug Abuse Directors (NASADAD); Johnny Allem; Clare Wisewasser (Al-Anon) and William Moyers. The National Forum and other efforts continued to bring key people and organizations together to speak with one voice.

1997 Borkman, T. J. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, 15(1), 37-42.

1998 Soberstock music festival held in Leesport, PA; the first of many recovery-oriented music festivals now held across the nation.

1998 White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* released.

New Recovery Advocacy Movement Milestones

1998 The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) awarded the first round of Recovery Community

Services Program (RCSP) grants. The awards were to organize the recovery community to provide public education and affect systems and policy change. Awards were to grassroots recovery community organizations for recovery community mobilization, policy advocacy and recovery-focused professional and public education. The grants seeded the development of many recovery community organizations, including those listed below.

- Association of Persons Affected by Addiction (APAA), Dallas, TX (1998)
- Connecticut Community of Addiction Recovery (CCAR) (1997)
- El Paso (Texas) Recovery Alliance (1998)
- Missouri Recovery Network (1999)
- The New England Alliance for Addiction Recovery (NEAAR), a network of recovery community organizations in CT, MN, MA, NH, RI & VT. (1998)
- The Pennsylvania Recovery Organizations Alliance (PRO-A) (1998)
- Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT), a grassroots recovery advocacy and support organization, founded by the Council of Southeast Pennsylvania. (1997)
- Recovery Communities United (IL) (1999)
- Recovery Association Project (RAP), Portland, OR (1998)
- Recovery Consultants of Atlanta (2000)
- Substance Abuse and Addiction Recovery Alliance (SARRA) of Virginia (1997)
- White Bison, Inc. to facilitate that Native American Wellbriety Movement (1998)

1999 A New PATH (Parents for Addition Treatment & Healing) founded in California by parents of children who struggle with addictive illness and who had experienced the devastation of the criminal justice system.

1998 Friends of Recovery Vermont founded, part of New England Alliance for Addiction Recovery (NEAAR).

1999 Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery*, 6(2), 11-23. Another call for reconnection between addiction treatment and long-term recovery.

2000 The RASE **(**Recovery, Advocacy, Service and Empowerment (RASE) Project founded in Harrisburg, PA.

2000 White, W. (2000) Toward a New Recovery Movement: Historical Reflections on Recovery, Treatment and Advocacy. Presented at Recovery Community Support Program (RCSP) Conference, April 3-5, 2000.

2000 Long Island Recovery Advocates (LIRA) founded.

1999-2001 William Cope Moyers serves as President of The Johnson Institute, raising $300,000 to launch the Alliance Project—an effort to mobilize the recovery community as an advocacy force; funded first-ever survey of the recovery community by Peter D. Hart & Associates to determine the willingness of the recovery community to participate in recovery advocacy movement. Jeff Blodgett is hired to head the Alliance Project.

2001 Alliance Project hosts the 2001 Recovery Summit in St. Paul Minnesota, bringing together people in recovery from multiple pathways. The Summit's goals were: 1). To celebrate and honor recovery in all its diversity, 2). To foster advocacy skills in the tradition of American advocacy movements, 3). To produce principles, language, strategy and leadership to carry the movement forward.

Faces & Voices of Recovery is founded at the Summit and its efforts are guided by a Core Positioning Statement:

> Long-term recovery from addiction to alcohol and other drugs is real for millions of Americans and thousands more get well every year. There are as many different paths to recovery as there are different people in recovery. But regardless of how people achieve recovery, their lives, and the lives of those they touch – their families and children – are vastly improved as a result. Those in long-term recovery are the living proof that recovery happens and that there are real solutions to the problem of drug and alcohol addiction.
>
> For too long a great majority of the recovery community – those in recovery, their families and recovery allies – have been silent about their experiences and successes. As a result, there has been no unified public voice advocating on behalf of recovery and for those who still need to achieve it.
>
> Times have changed. The recovery community is unifying around key priorities – to gain needed resources and to end discrimination against people in recovery. We are working to eliminate barriers to recovery for every American, every family and to help today's children and future generations, who often are the biggest winners in the process of recovery.
>
> The Faces & Voices of Recovery Campaign will mobilize the recovery community to advocate for recovery and help more Americans overcome addiction to alcohol and other drugs. The Campaign will allow recovery advocacy groups, already strong and active at the local level, to have a more prominent national presence.
>
> The Campaign will demonstrate that millions of individuals and families from every walk of life have found recovery from alcohol and other drug addiction. It will show that there are many paths to recovery – self-help, professional treatment, medical interventions – and that all of these paths have proven to work.
>
> The Campaign will actively support public policies to help all people have better access to recovery and to reduce the discrimination and stigma which keeps many people from seeking recovery or moving on to better lives once they achieve it. It will focus media and policymakers on the fact that without support for recovery, addiction will continue to be a massive and growing burden on society.
>
> The Campaign will show that helping those struggling with addiction to alcohol and other drugs benefits the entire community. It will promote widespread understanding that long-term recovery is a process that takes time and may even include episodes of relapse. Only when Americans have a sound appreciation of recovery, and fully understand the recovery process, will laws and policies be

effectively changed to reduce discrimination and lower barriers to recovery services.

Following the St. Paul Summit, a number of recovery community organizations are formed, including:

- Ohio Citizen Advocates for Chemical Dependency Prevention & Treatment (2001)
- Advocates for Recovery, Denver, CO (2001)
- People Advocating Recovery (PAR), Kentucky's statewide recovery community organization (2002)

2002: *Advocacy with Anonymity* brochure released by Join Together, Johnson Institute, Faces & Voices and NCADD and updated in 2006. Early versions of the brochure were out as early as 1998-1999.

2001 PRO-A, Pennsylvania statewide recovery community organization receives RCSP grant, collaborating activities through The RASE Project, Message Carriers and PRO-ACT.

2002 The Center for Substance Abuse Treatment (CSAT) switches the focus of the RCSP Program from advocacy and education to supporting organizations that enabled peers in stable recovery to help others avoid relapse and move into long-term recovery and rechristened the program the Recovery Community Services Program (RCSP). Some of the organizations funded under the RCSP program are:

- Detroit Recovery Project (2005)
- Medication Assisted Recovery Services Project (*MARS*), Bronx, NY (2006)
- RECOVER Project (a program of the Western Massachusetts Training Consortium) founded in Greenfield, Massachusetts (2003)

2002 The Hands Across the Bridge Project celebrates recovery through a walk across a bridge linking Oregon and Washington and attended by elected officials and thousands of people in recovery to help celebrate Recovery Month. It is sponsored by the Recovery Association Project (RAP), an original RCSP grantee.

2002 The Association of Recovery Schools founded at a Washington, D.C. meeting sponsored by the Center for Substance Abuse Treatment and attended by 13 recovery high schools and 3 collegiate recovery communities.

2003 Trilogy Recovery Community, Walla Walla, Washington, founded as an educational forums/groups for youth and their families. In 2009 Trilogy redefines itself as a recovery community organization, Trilogy Recovery Community.

2003 Alliance for Recovery Advocates (AFRA), Wisconsin's statewide recovery community organization founded.

2004 Learn2Cope, a parent support group, formed May 2004 in MA (Learn2cope.org) when a mother with a son addicted to opiates, spoke out at a community forum. With almost 4000 members today, Learn2Cope represents one of the first of a growing number of parent groups advocating and providing mutual support.

2004 Bi-partisan Congressional Addiction, Treatment and Recovery Caucus founded by Congressman Jim Ramstad (R-MN) and Patrick Kennedy (D-RI).

2004 Communities for Recovery, Austin, TX, founded.

2004 Tia Hart Community Recovery Program, Raeford, NC, founded.

2004 McShin Foundation, Richmond, VA, founded.

2004 Turning Point Recovery Center, Springfield, Vermont, founded (Turning Point is one of eleven Recovery Centers in Vermont organized as the Vermont Recovery Network.)

2004 Faces & Voices of Recovery becomes an independent 501 (c) (3) organization led by a 21-member board of directors.

2004 Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

2004 White, W. (2004). *The history and future of peer-based addiction recovery support services.* Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.
White, W. (2004). Recovery as Heroic Journey. *Recover Magazine*. 4(3), 18-21; 4(4), 18-21.
White, W. Recovery (2004). Rising: Radical recovery in America. Posted at www.facesandvoicesofrecovery.org

2004 Kingdom Recovery Center, St. Johnsbury, VT founded in the birthplace and childhood home of A.A. co-founder Dr. Robert Holbrook Smith, part of the Vermont Recovery Network.

2004 Public Opinion Survey of the General Public by Peter D. Hart Research Associates, Inc. and Robert M. Teeter's Coldwater Corporation on stigma, discrimination and other barriers to recovery from addiction to alcohol and other drugs for Faces & Voices of Recovery and focus groups of recovery community and general public by Peter D. Hart and Associates and Clearwater for Faces & Voices of Recovery and the National Council on Alcoholism and Drug Dependence. Recovery messaging developed and released by Faces & Voices of Recovery. http://www.facesandvoicesofrecovery.org/resources/public_opinion.php

2004 The Johnson Institute launches America Honors Recovery (In 2009, Faces & Voices takes over America Honors Recovery) to honor individuals and organizations serving the recovery community.

2004 Humphreys, K., Wing, S., McCarty, D., Chappel, J., Galant, L., Haberle, B.,..Weiss, R. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. *Journal of Substance Abuse Treatment*, 26(3), 151-158.

2005 Guide to Mutual Aid Resources launched at www.facesandvoicesofrecovery.org

2005 Faces & Voices of Recovery organizes over 70 house partiesto watch Dateline NBC's "Saving Carrick," a documentary about a young person's struggle with addiction to heroin.

2005 National Summit on Recovery convened by Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT).

2005 Recovery-oriented media including radio shows, magazines, blogs, Cable TV shows, SAMHSA's Road-to-Recovery and Recovery Month media and other resources grow.

2005 The Art of Recovery Expo (www.artofrecoveryexpo.com) founded.

2005 White, W. (2005) Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.

2005 White, W. & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, and advocacy. *Alcoholism Treatment Quarterly,* 23(4), 3-38.

2005 Connecticut Community for Addiction Recovery (CCAR) releases the film, The Healing Power of Recovery.

2005 Unity Hall – Recovery Communities founded in Fairfield, CA.

2005 National Summit on Recovery sponsored by SAMHSA, resulting in working definition of recovery. National Summit on Recovery Conference Report, 2005. Rockville, MD: Center for Substance Abuse Treatment.

2005 Faces & Voices of Recovery hosts National Recovery Summit in Washington D.C.

2006 Coyhis, D. & White, W. (2006). *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery-The Truth about the Lie*. Colorado Springs, CO: White Bison, Inc.

2006 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; White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care,* 3(1-2), 21-61.

2006 Utah Support Advocates for Recovery Awareness (USARA) founded.

2006 FAVOR SC founded to link four grassroots recovery advocacy organizations created since 2004 in South Carolina.

2006 *Advocacy with Anonymity* revised with new messaging.

2006 Partial repeal of the ban on Federal financial aid to students with prior drug convictions.

2007 Phoenix Multisport founded in Denver, CO by Scott Strode to foster a supportive, physically active community for individuals who are recovering from alcohol and substance abuse and those who choose to live a sober life.

2007 September Recovery Month celebrations: 30,000 people over 50 events, Liberty State Park, NJ, Faces & Voices national hub.

2007 White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241.

2007 First-ever Presidential Town Hall meeting addressing issues of addiction, prevention and recovery held in Plaistow, NH as part of Faces & Voices Recovery Voices Count, non-partisan civic engagement campaign.

2007 Faces & Voices of Recovery, Community Anti-Drug Coalitions of America (CADCA), and Join Together sponsor screenings, town hall meetings and house parties in conjunction with HBO's multi-platform campaign on "ADDICTION." 15,000 people attended over 500 viewing parties.

2007 White, W. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703.

2007 The Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33, 221-228.

2007 Valentine, P., White, W. & Taylor, P. (2007) The recovery community organization: Toward a definition. Posted at http://www.facesandvoicesofrecovery.org/pdf/valentine_white_taylor_2007.pdf

2007 Second Chance Act signed into law.

2007 Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, 33, 243-256.

2008 After Prison, Roadblocks to Reentry released by Legal Action Center, along with Toolkits for Advocacy about specific barriers. http://lac.org/roadblocks-to-reentry/

2008

- Message Carriers of Pennsylvania, Inc. becomes a 501 c (3) organization headquartered in Pittsburgh, PA (With roots dating back to the early 1990s as an affiliate of SOAR).
- Friends of Recovery New York, statewide recovery community organization, founded. Connecticut Turning To Youth and Families, Inc. (CTYF) founded.
- Voices of Recovery, San Mateo County, California, founded.
- Face It TOGETHER Sioux Falls founded.

2008 Connecticut Communities for Addiction Recovery (CCAR) forms the Recovery Technical Assistance Group (RTAG) to provide consulting, technical assistance to recovery community organizations and other entities, including Recovery Coach Academy.

2008 Recovery Month celebrations: 40,000 people, over 60 events, St. Louis, MO Faces & Voices national hub.

2008 White, W. (2008). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51; White, W. (2008) Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse,* 43, (12&13), 1987-2000.

2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Parity) signed into law. The Addiction Recovery Insurance Equity Campaign, working to end insurance discrimination against people with addiction, organized National Call-in Days; Capitol Hill rallies.

2008 Recovery Bill of Rights released by Faces & Voices of Recovery.

2008 Recovery Wellness rooms at Democratic and Republican National Conventions organized by Faces & Voices of Recovery and allied organizations. First Recovery Caucus held at Democratic National Convention.

2009 Johnson Institute programs and products transferred to the Hazelden Foundation Center for Public Advocacy.

2009 Recovery Month celebrations: 70,000 people over 80 events, New York City, NY Faces & Voices National hub; A&E Recovery Project with Recovery Delegates from all 50 states, New York City.

2009 Laudet, A., Flaherty, M., & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.

2009 White, W. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment,* 36, 146-58; White, W. (2009). *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

2010

- Minnesota Recovery Connection, Twin Cities recovery community organization, founded.
- Dorchester Recovery Initiative, Dorchester County, MD, founded.
- Citizens Organized for Recovery and Education-Illinois, statewide advocacy organization, founded

2010 McLellan, T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition: The Betty Ford Consensus Panel and consultants. *Journal of Substance Abuse Treatment*, 38, 200-201.

2010 Treatment Professionals in Alumni Services (TPAS) an organization of professionals and recovery volunteers interested in expanding alumni recovery support services in the U.S., founded.

2010 White House Office of National Drug Control Policy (ONDCP) and Faces & Voices of Recovery co-host roundtable on Peer Recovery Support Services in Health Reform

2010 ONDCP/SAMHSA Recovery Summit in Washington, DC (bringing in people in recovery from mental illness) – while some MH participants were invited, the theme of the summit was specific to addiction recovery.

2010 ONDCP creates Recovery Branch in its Office of Demand Reduction.

2010 Recovery Month celebrations, 80,000 people over 95 events, Philadelphia, PA Faces & Voices hub, first international Rally for Recovery! in United Kingdom.

2010 Coyhis, D. (2010). *The fulfillment of prophecy: The Wellbriety Movement comes of age*. Colorado Springs, CO: White Bison, Inc.

2010 Young People Networking Dialogue on Recovery sponsored by SAMHSA held.

2010 Recover Wyoming, Cheyenne, WY, founded.

2010 White, W. & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

2010 National Drug Control Strategy contains specific recovery section for first time.

2010 Addiction covered in health reform -- Patient Protection and Affordable Care Act (ACA).

2010 Inaugural Sober St. Patrick's Day party held in New York City “To reclaim the true spirit of the day and to change the perception and experience of what St. Patrick’s Day can be, both in the U.S. and abroad, by providing family friendly, alcohol-free events celebrating the best of Irish music, dance and comedy.” The event is sponsored by many people in recovery and recovery institutions.

2011 SAMHSA-sponsored recovery in health reform summit.

2011 National Association of Recovery Residences founded.

2011 Reach Out Recovery founded and documentary “The Secret World of Recovery” launched by Leslie and Lindsey Glass.

2011 Recovery Month celebrations, more than 90,000 people over 70 events, Faces & Voices hub in Philadelphia, PA.

2011 Faces & Voices forms the Association of Recovery Community Organizations (82 members by 2013).

2012 Faces & Voices members increase from 8,000 in 2005 to more than 30,000 in 2012

2012 Young People in Recovery (YPR) Steering Committee formed and meets to develop organization, National Council is formed, chapter development begins.

2012 Feliz, J. Survey: Ten Percent of American Adults Report Being in Recovery from Substance Abuse or Addiction. The Partnership at Drugfree.org and The New York State Office of Alcoholism and Substance Abuse Services. Retrieved July 17 from: http://www.drugfree.org/newsroom/survey-ten-percent-of-american-adults-report-being-in-recovery-from-substance-abuse-or-addiction

2012 Special issue of *Journal of Addictive Diseases* is dedicated to Lisa Mojer-Torres.

2012 Recovery Wellness Rooms held at Democratic and Republican National Conventions.

2012 First International Recovery Coach Conference held in London, England.

2012 First meeting of 25 New England Recovery Community Centers held.

2011-2012 Affordable Care Act implementation: Faces & Voices and state-side recovery community organizations advocate for the inclusion of recovery support services in state Health Exchanges and other policies to encourage enrollment and participation of people with addiction and people in recovery.

2012 Stop Stigma Now organized under leadership of Sy Demsky and Dr. Philip Paris to address stigma faced by patients in medication-assisted treatment.

2012 White, W.L. (2012). *Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Studies, 1868-2011*. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual disAbility Services Mental Retardation Services and Northeast Addiction Technology Transfer Center. Substance use remission prevalence in the U.S. estimated between 25-40 million adults based on available studies.

2012 Jason, L.A., Mericle, A.A., Polcin, D.L., White, W.L. & the National Association of Recovery Residences (with Fred Way serving as Liaison with Research Committee). (2012). A Primer on Recovery Residences in the United States summarizes the scientific evidence supporting the role of recovery residences in supporting long-term addiction recovery.

2012 Berridge, V. (2012). The rise, fall, and revival of recovery in drug policy. *Lance*t, 379, 22-23.

2012 El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine*, 6(1), 1-9.

2012 White, W. (2012). Family perspectives on medication-assisted recovery: An interview with Rolando Torres. Posted at www.facesandvoicesofrecovery.org and www.williamwhitepapers.com

2013 Laudet, A.B. & Humphreys, K. (in press). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services? *Journal of Substance Abuse Treatment*.

2013 The Anonymous People documentary by filmmaker Greg Williams screened.

2013 “Life in Recovery,” first-ever survey of over 3000 individuals in recovery documenting their life experiences, released by Faces & Voices of Recovery. Posted at www.facesandvoiesofrecovery.org

The authors would appreciate your comments (omission, correction and updates) on the Chronology. Please email them to us at info@facesandvoicesofrecovery.org. Thank you.

May 2013.



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: Evans, A.C., Lamb. R. & White, W.L. (2013). The community as patient: Recovery-focused community mobilization in Philadelphia, 2005-2012. *Alcoholism Treatment Quarterly*, 31(4), 450-465. Posted at **www.williamwhitepapers.com**

The Community as Patient: Recovery-focused Community Mobilization in Philadelphia, PA (USA), 2005-2012

Arthur C. Evans, Jr, PhD, and Roland Lamb, MA
Philadelphia Department of Behavioral Health and Intellectual disAbilities, Philadelphia, Pennsylvania USA

William White, MA
Chestnut Health Systems, Bloomington, Illinois USA
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The concept of recovery within the addictions arena has historically referred to the resolution of severe alcohol and other drug (AOD) problems at a personal or family level. Larger social systems can also be wounded by and experience recovery from the prolonged effects of AODs and related problems. This paper explores the concept of community recovery, posits a set of preliminary principles related to community recovery, presents a case study of community recovery, and outlines current strategies used in the City of Philadelphia to promote processes of community recovery.

KEYWORDS Recovery management, recovery-oriented systems of care, community recovery capital, community recovery, recovery support services

Introduction

Recovery is emerging as a central organizing concept for the transformation of addiction treatment and the broader redesign of behavioral health care in the United States (Evans, 2008; ONDCP, 2010; ONDCP & SAMHSA, 2010; White, 2005, 2008a,b). Recent efforts to more precisely define recovery have emphasized reconstruction of the person-community relationship as a central element of the personal recovery experience. The Betty Ford Institute Consensus Panel (2007) included “citizenship” as a component of recovery, and the UK Drug Policy Commission Recovery Consensus Group (2008) included “participation in the rights, roles and

responsibilities of society" in its definition of recovery. White (2007a), reflecting the broader conceptualization of recovery within Native American (Coyhis & White, 2006) and African American (Achara-Abrahams et al., 2012; Sanders & Powell, 2012; White & Sanders, 2008) communities, subsequently depicted recovery as a healing process that could move beyond individuals and families to encompass whole communities. Those spheres of recovery are graphically depicted below and placed within the framework of the Native American medicine wheel.

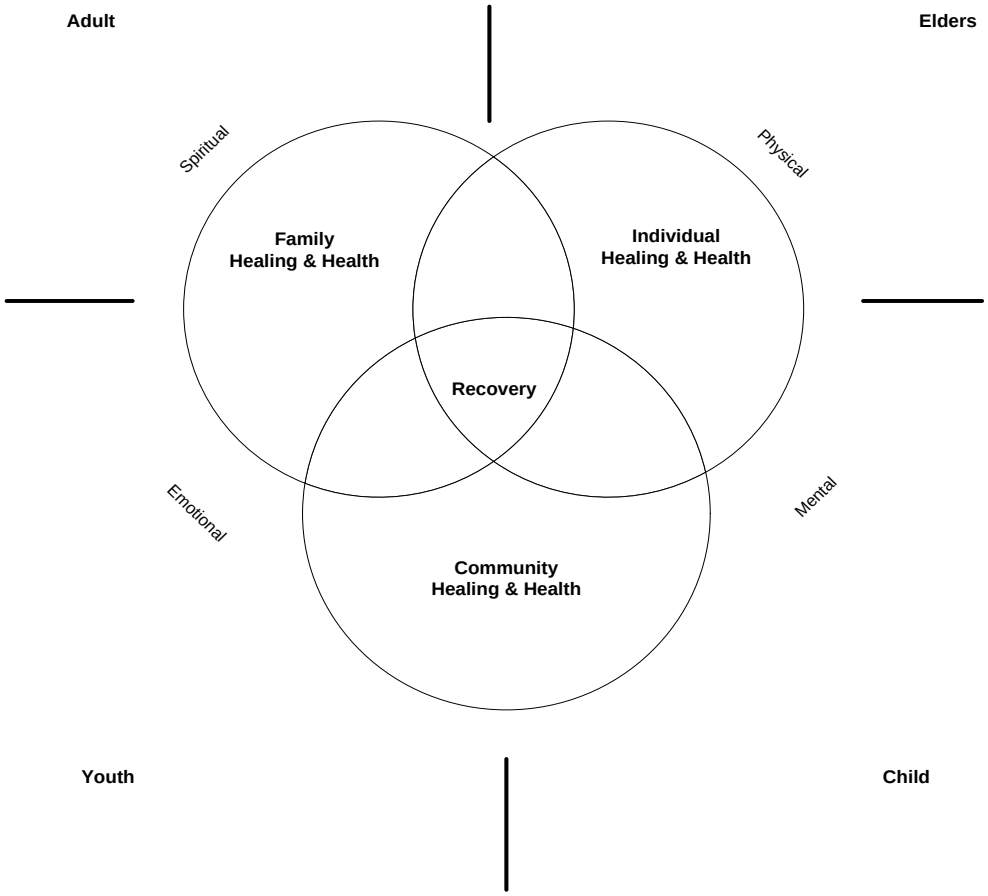


Figure 1 Recovery and the life cycle of the individual, the family and the community. Source: Charlene Belleau, Former Chief, Alkali Band of Indians (White 2007a, p. 237)

While a process of community recovery has been suggested in this earlier work, the concept of community recovery has not been defined and amplified. The purpose of this article is to draw on the authors' collective experience within a recovery-focused behavioral health care 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.

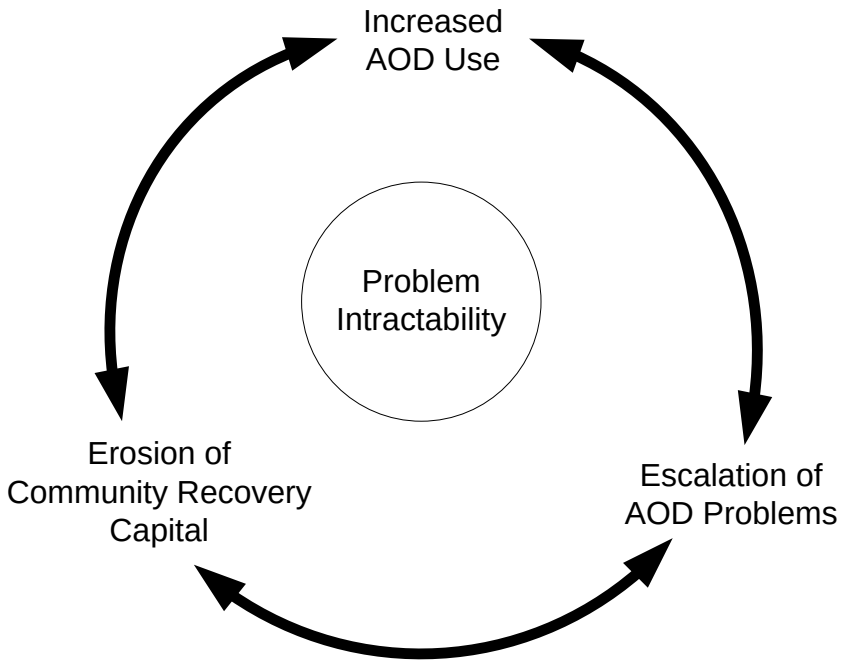


Figure 2: Problem Intractability and Personal/Community Demoralization

The etiology of AOD problems has long been portrayed within two primary organizing lenses: personal vulnerability (a genetically influenced disease process warranting medical treatment) and personal culpability (a moral weakness warranting character reconstruction or 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 (Humphreys, Moos, & Cohen, 1997; Karriker-Jaffe et al., 2012). These contextual influences constitute the soil in which AOD problems flourish or are squelched at personal, family, neighborhood, and community levels. These influences also determine whether severe AOD problems are personally and socially intractable or amenable to prevention, early intervention, treatment, recovery support, and broader community 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 demands for adaptation. Most communities have the internal resources to respond to these stressors, and AOD problems in such communities remain primarily limited to a small percentage of community members with particular vulnerability for such problems and who are disconnected from community support systems. In such circumstances, problem contagion is limited and contained within marginalized subcultures.

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. Under conditions of community distress, personal, family, and cultural deterioration unfolds, and these elements interact synergistically to rapidly increase the prevalence and severity of AOD problems. Under these circumstances, problem contagion and its resulting progeny (e.g., family dissolution, child abuse/neglect, homelessness, crime, violence, and infectious diseases) become shrouded in an aura of intractability that in turn feeds collective frustration, hopelessness, apathy, and resignation. This loss of community self-efficacy can trigger aggression—shunning, scapegoating, punishment, community extrusion—of those viewed as problem vectors.

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 socially contagious and 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; Brave Heart, Chase, Elkins, & Altschul, 2011; Morgan, 1983). Over time, learned helplessness and hopelessness in the face of such problems can become part of the community culture conveyed across generations awaiting a process of community recovery.

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 subsequent 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 a 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, Swidler, & Tipton, 1985).
- Weakened family, kinship network, neighborhood, and natural community ties diminish personal and collective capacities to respond to rising problems (Bloom, 1997).
- Alternative social structures (from gangs to mutual aid groups to cell phone and internet-based social networking) meet social support needs once met by traditional social institutions (e.g., families, extended families, churches, schools, workplaces, civic organizations; White, 2001).
- The industrialization and commercialization of personal compassion (via ever-growing health and social services agencies) and social control (via ever-growing police, courts, correctional, and child protection agencies) may have inadvertently hastened the dissolution of family, kinship, neighborhood, and community ties (McKnight, 1995).
- Interventions into AOD and related problems must move beyond micro-level (individual) interventions to the creation of "naturally occurring, healing environments" that simultaneously elevate personal, family, and community health (Bloom, 1997, p. 117).

Strategies of community development and renewal, embraced here within the conceptual rubric of *community recovery*, can complement 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, 2001, 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 levels of prevalence and severity that threaten collective health and functioning. In short, systems can become impaired by addiction and the broader arena of AOD problems and reach a level of such impairment that system vitality and viability are threatened. 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 are routinely collected by 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 breakthrough in community consciousness (acknowledgement and clear definition of problems) and sustained community commitment and 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; 4) enhancing the long-term health and quality of life within major community institutions and the community as a whole; and 5) implementing strategies designed to break intergenerational cycles of problem transmission.

Community recovery is a *process* in that it must unfold and be sustained over a prolonged period of time. It is not an event or a time-limited special project. 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 AOD-related problems and imbedding personal, family, and cultural resistance and resilience as an enduring intergenerational legacy within the fabric of community life.

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 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 and control 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, families, and neighborhoods; 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 past and continued 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 we were wounded by these problems?
- What happened to us as a result of these problems?
- What sparked the recovery process?
- Who and what are we now and where are we going as a community?

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; the arts community; and media institutions. The catalysts for community recovery can come from any one of these sectors, but the long-term recovery and community renewal is only possible 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 community recovery capital, e.g., increases in recovery prevalence, pro-recovery community policies, and enrichment of 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.). These resources can then be mobilized to reduce future levels of AOD problems within the community, creating strategic integration of harm reduction, primary prevention, early intervention, treatment, and recovery support efforts.

Community recovery diminishes the necessity of future personal and family recovery by lowering personal/family vulnerability and heightening personal/family resilience and resistance.

Community recovery elevates the prognosis for personal/family recovery by elevating external recovery capital, creating the physical, psychological, and cultural space where recovery can flourish, and increasing the density of recovery carriers (persons who convey infectious hope and guidance for recovery initiation/maintenance) within the community.

A Brief Case Study in Community Recovery

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 five 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, 2011; Wadden, 2008).

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).

Community Mobilization in Philadelphia

For the past five years, the authors have been involved with the Philadelphia Department of Behavioral Health and Intellectual disAbility Services' recovery-focused system transformation efforts (See Achara-Abrahams, Evans, & Kenerson King, 2011; Evans & Beigel, 2006; Lamb, Evans, & White, 2009; White, 2007b). As this initiative 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 the idea of community recovery as both a goal and method.

Through this systems transformation process, several strategies emerged that promoted recovery at these multiple levels. 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 people from throughout the community	Conducting ongoing focus groups, town meetings, and other listening forums; eliciting personal, family, neighborhood, and community recovery 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. Personal and collective healing can occur through 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	Distress breeds isolation and "us versus them" thinking at all levels of the community; closed systems open only via increased boundary transactions and cross-boundary relationships.

	between service providers and the larger community.	
Forge or strengthen old and new partnerships	Desiloization: experiments in co-location; pushing integrated solutions to entangled problems; creating win-win outcomes for joint collaborations; 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 disease.
Create synergistic effects through integrated and linked projects	Funding recovery support services within non-traditional settings; experimenting with co-location of services and development of multi-agency service and support 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 local communities.
Strengthen natural supports beyond professional service systems	Supporting grassroots efforts that provide support to the broader community; developing faith-based initiatives related to substance use prevention and personal/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.	Long-term recovery support is best provided within relationships that are natural, non-hierarchical, non-professionalized, non-commercialized, and marked by sustained continuity of contact over time. 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; creating a stigma committee to develop a strategy for long-term stigma reduction.	Intolerance, stigma, and intergroup conflict are symptoms of community distress. The most effective stigma reduction strategy is a relational contact strategy.
Inspire hope	Hosting recovery celebration events and recovery conferences; sponsoring recovery mural arts projects in the community; Recovery Idol music contests; importing and locally developing charismatic speakers on	Recovery initiation hinges on changing prevailing pessimism—elevating the idea that personal, family, and community recovery is both possible and a growing reality. People who were once part of the problem can be transformed and mobilized as part of the solution.

	addiction recovery and recovery advocacy.	
Cultivate a network of recovering communities for mutual support	Visibly promote community recovery successes; exchange visits with other communities at national and international levels for mutual support and sharing of ideas and methods.	Internal and external recognition of local community efforts increases community self-esteem and enhances motivation for sustained system transformation efforts.
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 Recovery Advisory Committees and multiple time-limited task forces.	Community recovery initiation is enhanced by mobilizing internal recovery capital. Community service is a vehicle of personal and community healing. Expanding service opportunities for people in recovery enhances personal and community recovery.
Mobilize external resources	Increasing procurement of federal, state, 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.
Increase trust	Maintaining consistent 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 community.
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 frontline 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.
Measure community recovery capital	Mapping problem severity and recovery capital by zip code; conducting recovery prevalence surveys; establishing recovery-focused system performance benchmarks.	Resources can be strategically allocated to ensure that efforts to increase recovery capital reach those areas in greatest need. Solutions-focused public communications enhance community optimism and expand recovery support capacity.
Steward limited financial resources	Providing free consultations on recovery support development; using mini-grants to treatment providers, recovery community organizations, and other service organizations to expand availability and quality of recovery support services.	Many efforts that increase community recovery capital require minimal or no financial resources.

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 people in need and indigenous recovery support resources. Those resources included professional assistance in recovery initiation, but the emphasis was on support that was voluntary, reciprocal, enduring, and non-commercialized (Mulford, 1976, 1978; White, 2001, 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, treat, and discharge individuals and families impacted by severe alcohol and other drug problems. That approach, upon which the modern addiction treatment industry was built, defined the source and solutions to addiction at the microsystem level (individual and limited attention to family). Neither model conceptualized the community as the "patient" (White, 2003).

In contrast, a profound understanding of the concept of wounded community and the potential for community recovery can be found within historically disempowered groups, particularly within 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, 2002). 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 and subsequently lost again. What is called for in this

metaphor 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 ecologically nested within 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 already well under way.

About the Authors: Dr. Arthur Evans, Jr. is Director of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBH/IDS). Roland Lamb is the Director of the Office of Addiction Services, Philadelphia DBH/IDS. William White is a Senior Research Consultant at Chestnut Health Systems.

Acknowledgement: Support for the development of this paper was provided by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

References

Abbott, P. J. (1998). Traditional and western healing practices for alcoholism in American Indians and Alaskan Natives. *Substance Use and Misuse, 33*(13), 2605-2646. doi:10.3109/10826089809059342

Achara-Abrahams, I, Evans, A. C., & Kenerson King, J. (2011). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science.

Achara-Abrahams, I., Evans, A. C., Ortiz, J., Villegas, D. L., O'Dell, J., Ali, O., & Hawkins, D. (2012). Recovery management and African Americans: A report from the field. *Alcoholism Treatment Quarterly*, *30*, 263-292. doi:10.1080/07347324.2012.691049

Bellah, R., Madsen, R., Sullivan, W., Swidler, A., & Tipton, S. (1985). *Habits of the heart: Individualism and commitment in American life*. New York: Harper & Row.

Ben, L. W. (1991). *Wellness circles: The Alkali Lake model in community recovery processes* (Unpublished doctoral dissertation). Northern Arizona University, Flagstaff.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*(3), 221-228. doi:10.1016/j.jsat.2007.06.001

Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies.* New York: Routledge.

Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13. doi:10.1080/02791072.2003.10399988

Brave Heart, M. Y., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma

among indigenous peoples of the Americas: Concepts, research and clinical considerations. *Journal of Psychoactive Drugs*, *43*(4), 282-290. doi:10.1080/02791072.2011.628913

Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal, 8*(2), 60-82.

Chelsea, P., & Chelsea, A. (Producers). (1985). *Honour of all: The people of Alkali Lake* [Video]. British Columbia, Canada: The Alkali Lake Tribal Council.

Coyhis, D., & White, W. L. (2002). Alcohol problems in Native America: Changing paradigms and clinical practices. *Alcoholism Treatment Quarterly*, *20*(3/4), 157-165. doi:10.1300/J020v20n03_10

Coyhis, D. L., & White, W. L. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery*. Colorado Springs, CO: White Bison, Inc.

Douglass, F. (1855). *My bondage and my freedom*. New York: Miller, Orton, & Mulligan.

Evans, A. (2008). *The recovery-focused transformation of an urban behavioral health care system*. In W. L. White (Ed.), *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright)* (pp. 39-58). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Evans, A. C., & Beigel, A. (2006, February). *Ten critical domains for system transformation: A conceptual framework for implementation, evaluation & adaptation*. Presented at the 16th Annual Conference on State Mental Health Agency Services Research, Program Evaluation & Policy, February, Baltimore, MD.

Hacker, G., Collins, R., & Jacobson, M. (1987). *Marketing booze to Blacks*. Washington, DC: Center for Science in the Public Interest.

Haggerson, P. (2011). The honour of all: Twenty-five years of inspiring recovery from alcoholism. *Counselor, 12*(5), 10-13.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231-238.

Karriker-Jaffe, K. J., Zemore, S. E., Mulia, N., Jones-Webb, R., Bond, J., & Greenfield, T. K. (2012). Neighborhood disadvantage and adult alcohol outcomes: differential risk by race and gender. *Journal of Studies on Alcohol and Drugs*, *73*, 865-873.

Lamb, R., Evans, A. C., & White, W. L. (2009). *The role of partnership in recovery-oriented systems of care: The Philadelphia experience*. Retrieved from www.facesandvoicesofrecovery.org

Lurie, N. (1974). The world's oldest on-going protest demonstration: North American Indian drinking patterns. In N. Hundley (Ed.), *The American Indian* (pp. 55-76). Santa Barbara, CA: CLIO Books.

McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books.

Morgan, P. (1983). Alcohol, disinhibition, and domination: A conceptual analysis. In R. Room & G. Collins (Eds.), *Alcohol and disinhibition: Nature and meaning of the link* (pp. 405-422). Washington D.C.: U.S. Government Printing Office.

Mulford, H. (1976, June). *Alcohol abuse and citizen action: The community counselor/consultant approach*. Presented at the Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependence, Toronto, Canada, June 20-25, 1976.

Mulford, H. (1978, September). *Accelerating the natural alcoholic recovery process*. Presented at the 32nd International Congress on Alcoholism and Drug Dependence, Warsaw, Poland.

ONDCP. (2010). New drug policy approach focuses on vital role of recovery. *ONDCP Update*, *1*(1), 2. Washington D.C.: Office of National Drug Control Policy.

ONDCP & SAMHSA. (2010). *National summit on recovery from substance use disorders*, *September 14, 2010*. Washington D.C.: Office of National Drug Control Policy and Substance Abuse and Mental Health Services Administration.

Sanders, M., & Powell, J. (2012). Multiple pathways of recovery for African American men. *Alcoholism Treatment Quarterly*, *30*(3), 315-325. doi:10.1080/07347324.2012.690697

The red road to wellbriety (2002). Colorado Springs, CO: White Bison, Inc.

Taylor, V. (1987). The triumph of the Alkali Lake Indian band. *Alcohol Health and Research World, 12*(1), 57.

The UK Drug Policy Commission Recovery Consensus Group. (2008). *A vision of recovery*. UK Drug Policy Commission.

Wadden, M. (2008). *Where the pavement ends: Canada's aboriginal movement and the urgent need for reconciliation*. Vancouver, British Columbia: Douglas & McIntyre.

Waldorf, D. (1973). *Careers in dope*. New Jersey: Prentice Hall.

White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. L. (2001). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly, 19*(4), 1-32. doi:10.1300/J020v19n04_01

White, W. L. (2003). The road not taken: The lost roots of addiction counseling. *Counselor*, *4*(2), 22-23.

White, W. L. (2005) Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, *23*(1), 3-15. doi:10.1300/J020v23n01_02

White, W. L. (2007a). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*(3), 229-241. doi:10.1016/j.jsat.2007.04.015

White, W. L. (2007b). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

White, W. L. (2008a). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. L. (2008b). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright)*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158. doi:10.1016/j.jsat.2008.10.006

White, W. L. (2010). *Recovery is contagious*. Retrieved from www.facesandvoicesofrecovery.org and www.williamwhitepapers.com.

White, W. L., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395. doi:10.1080/07347320802072198

Williams, C., with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York: Harper San Francisco.



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. & Sanders, M. (2013). Heroism and addiction recovery revisited: An interview with William White. Posted at **www.williamwhitepapers.com**

Heroism and Addiction Recovery Revisited

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

A hero is someone who understands the responsibility that comes with his freedom.
--Bob Dylan

Introduction

This is the second in a series of interviews with William White on subjects of interest to my students and trainees. More than a decade ago, Bill penned an essay about addiction recovery as a heroic journey. The essay went on to become widely read and become something of an iconic piece of literature in the newly rising addiction recovery advocacy movement. I recently asked Bill to revisit this subject. Please join us in this further exploration of heroism and addiction recovery.

Mark Sanders, May, 2013.

Earlier Writing on Heroism and Recovery

Mark Sanders: How did you first get interested in heroism and addiction recovery?

Bill White: This interest was triggered by witnessing people in early recovery who personified their struggle through references to battling demons, monsters, or dragons. What was particularly striking to me was the kind of commitment—a *recovery by any means necessary under any circumstances* kind of commitment—that could overcome what on the surface seemed almost insurmountable odds against successful long-term recovery. I had come to think of this struggle in terms of strength and courage, but it wasn't until rereading Joseph Campbell's *The Hero with a Thousand Faces* that I began to conceptualize recovery as a heroic journey.

Mark Sanders: What perspectives did Campbell contribute to your thinking about recovery?

Bill White: Campbell described a common three-part structure to the heroic tales and myths he found in all cultures: the hero's departure from home and community and entry into an unknown world, the hero's transformation through tests of courage and character, and the hero's return. Campbell's

description of this process struck me as very similar to the recovery process. I wrote twin articles on this comparison. The first (White, 2001a) depicted recovery as a potentially heroic journey but raised the provocative question of whether people in recovery are successfully completing the final stage of this journey. According to Campbell, the most difficult stage of the hero's journey is the return home and reentry into and reconciliation with the family/community the hero left behind. To complete the journey in Campbell's view, the hero must deliver his/her newfound knowledge to the community. The first article I wrote suggested that many people in recovery had not yet fully reentered their communities or delivered the fruits of what they had learned. It suggested that recovery could be a heroic journey but one that was often unfulfilled due to the omission of this final stage. The second article, entitled The Boon of Recovery (White, 2001b), speculated on what those gifts to the community drawn from the recovery experience might entail.

Mark Sanders: What was the response to these early papers?

Bill White: These papers were written early in the history of the New Recovery Advocacy Movement in the U.S., and I think they helped imbue recovery and recovery activism with a sense of nobility and higher purpose. They were written directly to people in recovery who proved to be a most appreciative audience. My discussion of what precisely was heroic about recovery was very vague in these early papers. It wasn't until I later began to read the scientific literature on heroism that my own understanding of this link became clearer.

A Deeper Understanding of Heroism

Mark Sanders: What scientific studies exerted the most influence on your thinking?

Bill White: Zeno Franco, Kathy Blau, and Philip Zimbardo have collaborated on a number of studies and papers that have been very important to my own evolving thoughts on heroism and recovery. Most importantly, they helped me distinguish between heroism and other positive attributes or behaviors such as compassion, altruism, courage, and fortitude. For example, one can overcome great challenges, be helpful to others, and achieve greatness in one or more areas of endeavor without any of these reaching the status of heroism. Franco, Blau, and Zimbardo helped increased the precision of my thinking about what aspects of recovery might be thought of as heroic.

Mark Sanders: Heroism has always seemed to me much more common than how it is culturally portrayed.

Bill White: Zeno Franco and his colleagues raise the question of whether heroic acts are the province of an almost superhuman elite or actions available to us all—even those of us whose less than noble pasts would not usually qualify us as potential heroes. They conclude that we are all capable of heroism and that heroic acts can include *principle driven heroism*—acts of passive resistance in the face of enormous pressure to conform—as in the case of civil rights icon Rosa Parks' refusal to move to the back of the bus so a white person could take her seat.

Mark Sanders: What criteria do they use to distinguish the heroic?

Bill White: For them, heroism must be voluntary. It must be in service to others in need. There must be no anticipation of personal gain. It must entail risks of physical/social injury to self. And the individual must act with a willingness to accept the consequences of such risks. All five elements must be present to meet their definition of heroism. Numerous acts of service to others without expectation of personal gain are worthy of commendation as are all manner of personal achievements, but such actions fall short of heroic in the Franco/Blau/Zimbardo framework unless they involve elements of potential harm to

self and acting with full willingness to accept the outcome of those risks.

Mark Sanders: These elements would seem to defy the popular conception of heroes as cultural celebrities or individuals whose stories have captured our attention because they have overcome great obstacles.

Bill White: Yes, it quickly becomes apparent that the vast majority of people portrayed as heroes by the popular press do not meet the hero criteria.

Heroism and Recovery

Mark Sanders: How do you see these five elements of heroism in relationship to recovery from addiction? Heroism must be voluntary.

Bill White: If there is anything with the recovery experience that is heroic, recovery itself must be voluntary, meaning that it is entered into willfully and purposely. Now this is not to say that many people do not enter recovery under all kinds of false pretenses—under external duress, as an intended brief respite from "the life," or as a brief experiment in abstinence. I've often said that many people enter what will become their early days of recovery not because of the monkey on their back but the people on their butt. And then something happens—they get caught up in recovery not unlike the way they may have got caught up in addiction. They catch it with no more intent than you would catch a cold. And this often happens through exposure to one or more recovery carriers—people who make recovery contagious through their character and the way they conduct their lives. But at some point, recovery—if it is to be authentic and sustainable—must be personally and consciously embraced. It must be a product of choice. And those actions that flow out of recovery that are to be considered heroic must also flow from voluntary choice.

Mark Sanders: Heroism involves service to others?

Bill White: "You must get sober (or clean) for yourself; you can't do this for anyone else" is an aphorism often heard within various communities of recovery, but heroism is not about self-centeredness or even rational self-interest. There is nothing heroic about running into a burning building to save someone with the primary motivation being the hope for personal recognition by others. (This is narcissism elevated to the level of madness!) Two things make such an act heroic: the lost sense of self and the intense sense of human connectedness to those in jeopardy—a sense so deep within us that it is acted upon in a second. There is sometimes the portrayal of heroism as a process of self-assertion, but heroism is not as much about the assertion of self as the transcendence of self—abandoning and at the same time risking self for a higher purpose.

Mark Sanders: And heroism does not involve expectation of personal gain?

Bill White: It can't. That is why true heroes are so uncomfortable with any public attention surrounding their actions. Such focus on self is the very antithesis of the heroic character. Media frenzies that turn the hero into a celebrity of the moment corrupt the very source of the heroic act. The media aftermath elevates and objectifies the individual self (at least temporarily), whereas the heroic act itself involved a leap beyond the self.

Mark Sanders: What about the issue of risk of physical/social injury to self?

Bill White: Ah, that is a very special dimension of heroism. Running into the burning building or diving into turbulent waters to rescue someone clearly manifest this dimension of risk, but what aspects of recovery involve such risks? There are obvious risks one can face during his or her addiction career, but these do not qualify as heroic because they were in service not to a noble purpose but to what those addicted sometimes refer to as serving the beast

within—chasing the dragon. So what risks of physical or social injury does the person in recovery face in service to a larger purpose?

The most significant of such risks occurs in what Campbell referred to as the final stage of the hero's journey—returning to bestow lessons learned from one's journey to family and community. Addiction is a disease of disconnection. It first erodes the family and social capital one has acquired and then turns all people into objects to be exploited for one's own needs. Addicted people develop, often by effect rather than intent, a predatory orientation to human relationships, inflicting deep wounds (sins of omission and commission) on those who enter the orbit of their influence. The person-drug relationship becomes so consuming that all else is sacrificed. It is this disconnection and its consequences on self and others during addiction that sets the stage for the one truly heroic aspect of recovery: retracing the path of addiction backwards as a person in recovery to make amends and restore one's place in the non-addict universe.

The journey home requires more courage than anything that was faced in addiction because it requires a movement out of the self and into relationships while taking full responsibility for the carnage of one's past. There are many difficult challenges in the recovery journey but none that involves more risks for the traveler than Campbell's final chapter—the return to heal the past and serve others in the present (e.g., AA/NA's Steps Eight, Nine, Ten, and Twelve). Taking risks, acts of personal rebellion, challenging every conceivable rule and boundary for sake of self is far too familiar to many of us; that is not heroism. What distinguishes heroism is that the risks and crossed barriers flow out of reconnection to others and risks taken on behalf of others.

Mark Sanders: And finally, the willingness to accept consequences of such risks?

Bill White: Heroism does not entail obliviousness to risk; it is acting in full consciousness of the risks and potential consequences to self. It also involves the potential of refusing to act when to do so could harm others. Let me give you an example that will tie some of these elements together. For those in 12-Step recovery, there is no step that involves greater risk of harm to self and others than the Ninth Step ("Made direct amends to such people [all person we had harmed] wherever possible, except when to do so would injure them or others.") The Ninth Step is the ultimate act of returning home to clean up debts and close unfinished business. Fear of injury to self is not a rationale for failing to make amends. In fact, conquering fear of the risks involved and proceeding to voluntarily make amends because of the benefit of such acts to others with no expectation of personal gain and readiness to "take the full consequences of our past acts" is the essence of the Ninth Step and contains all five of the earlier noted elements of heroism (Alcoholics Anonymous, *Twelve Steps and Twelve Traditions*, p. 87, underline added). Also of interest is the exception built into the Ninth Step—to refrain from making amends when to do so could harm, not the person making amends, but the party to whom the amends should be made as well as other related parties. This exception further reinforces that these acts of amends and restitution must be taken or not taken as an act of service to others rather than for the emotional comfort or therapeutic benefit of our protagonist.

Mark Sanders: Are you saying that recovery itself is not heroic, but that there may be aspects of the recovery process that rise to this level of heroism?

Bill White: Yes, recovery from addiction is a challenging and valuable achievement, but it should not bestow nobility on the recovering person greater than that given persons who have never experienced addiction. I should not expect accolades from my community because I stopped harming myself and ceased harming nearly everyone within my sphere of influence. Recovery from addiction does not, and I don't think should, come with that kind of cultural entitlement and privilege. America loves second acts and we have

long celebrated the person who rises in triumph from the ashes of defeat. Such stories confirm our aspirational value (or myth) of unlimited possibilities for all, but I don't think recovery in and of itself rises to the level of heroism as we've defined it in this discussion. The potential for heroism comes not from recovery status but from heroic acts that some choose to take within or beyond the recovery process.

Mark Sanders: Could you provide another example of such heroism in the context of recovery?

Bill White: Yes. The other area of heroism that immediately comes to mind involves asserting one's recovery status to the community, not as an act of self-aggrandizement, but as an act of service. This brings us back to Campbell's *The Hero with a Thousand Faces*. For the hero journey to be complete in Campbell's view, the hero must return home to family and community to bestow the lessons learned on the journey. People in recovery do that through acts of community service and public recovery advocacy. It is the stigma—the social indictment—attached to addiction that poses risks to the person in recovery. The recovery advocate faces potential personal embarrassment, loss of social standing, and the loss of professional or financial standing through this act of service. And it is precisely such risks that bring to recovery advocacy this dimension of heroism. By analogy, there was nothing heroic about people like Ryan White and Ervin "Magic" Johnson becoming infected with HIV/AIDS, seeking treatment for AIDS, and actively participating in their own AIDS recovery management. What was heroic was their going public with this status and turning their personal tragedies into an opportunity for public service at a time when there was enormous social stigma attached to HIV/AIDS. What makes recovery advocacy heroic is not the advocate's recovery status, but returning back to the community at great personal risk to bestow the lessons of recovery for the benefit of others without expectation of personal benefit.

Mark Sanders: How do you reconcile this heroism through recovery advocacy with anonymity as the "spiritual foundation" of all 12-Step program traditions?

Bill White: Anonymity served many practical functions in the early decades of AA, and quite animated discussions continue on the extent to which these functions continue or do not need to continue in the twenty-first century. Three such practicalities were most prominent. First, anonymity at the level of press (and the cultural etiquette of not using last names within meetings and admonitions of "who you see here, what you hear here, when you leave here, let it stay here") helped attract and protect the identities of alcoholics whose affiliation with AA, if publicly known, could cause harm to them or other parties. Second, anonymity at the level of press protected AA from public damage to its reputation that could occur if a publicly identified AA member or leader experienced a resumption of destructive drinking and related mayhem. The principle of anonymity and the practice of leadership rotation also helped AA avoid the organizational pitfalls of charismatic leadership and a centralized hierarchy that publicly personified AA. That function was particularly significant at an organizational level within a fellowship that defined the central problem of its members in terms of "self-centeredness," "self-will run riot" and "playing God." (Alcoholics Anonymous, 1939, pages 23, 74, 75). An argument could be made that the social stigma attached to alcoholism has declined in recent decades, making the first two functions less vital, although I don't think this same argument could be made in such 12-Step groups as Narcotics Anonymous, Cocaine Anonymous, Heroin Anonymous, and other 12-Step groups for persons addicted primarily to illicit drugs.

Mark Sanders: And what about the current status of these other functions?

Bill White: I still see the value of anonymity at the level of press as a protection of all 12-Step programs, and leaders within the new

recovery advocacy movement distinguish public disclosure of recovery status (including at the level of press) with disclosure of one's affiliation with AA or another 12-Step program at the level of press. I think disclosure of recovery status at the level of press without reference to affiliation with AA or another 12-Step program complies with the letter of Traditions Ten & Eleven, but it may not always meet the spirit of the Traditions (Tradition Twelve).

Mark Sanders: Explain what you mean by that.

Bill White: I think the practical justifications for anonymity change and may even be lost as cultural contexts change, but anonymity as "spiritual foundation" comes from a quite different source—not cultural context and the personal or organizational threats such context pose, but from the essential dilemma of individuals seeking recovery within a 12-Step framework.

One of the central discoveries within AA was that the alcoholic could not recover using only resources within the self. The alcoholic's essential problem, whether as a cause or consequence of alcoholism, was in 'AA's view entrapment within the self. The most cursory scan of AA's basic text, *Alcoholics Anonymous*, is informative. AA's founding generation viewed such things as self-awareness, self-knowledge, self-control, self-discipline, self-assertion, self-reliance, and self-confidence not as virtues but as part of the central pathology of alcoholism (along with other self-hyphenated conditions, e.g., self-justification, self-pity, and self-deception). So what AA constructed via its steps and rituals was a "we program" rather than an "I program" of recovery that allowed the alcoholic to escape entrapment within the self—a program that required nothing less than the "destruction of self-centeredness" (AA, 1939, p. 30).

When AA literature speaks of anonymity as a "spiritual principle," it does so out of a profound understanding of the importance of self-transcendence as the vehicle for sobriety and serenity. You can hear people depicting AA as a "selfish program" to mean that the alcoholic must get sober for self and not for others, but you find a quite different orientation on the issue of anonymity. The "spiritual substance" of anonymity according to AA's core literature is not selfishness but "sacrifice." (Alcoholics Anonymous 1952/1981, p. 184). What is sacrificed in AA (and in acts of heroism) are one's "natural desires for personal distinction," which in AA are eschewed in favor of "humility, expressed by anonymity" (Alcoholics Anonymous, 1952/1981, p. 87).

Applying this understanding, one could see how an AA or NA member choosing public recovery advocacy could technically meet the letter of Tradition Eleven (not disclosing AA affiliation at the level of press), but violate the pervading spirit of the Traditions (Tradition Twelve). This could occur when advocacy is used as a stage for assertion of self (flowing from ego / narcissism / pride and the desire for personal recognition) rather than as a platform for acts of service, which flow from remorse, gratitude, humility, and a commitment to service. Acts flowing from the former could never rise to the level of the heroic, but acts flowing from the latter might well qualify as heroic (and honor the spiritual intent of anonymity) if they meet the other criteria we have discussed.

Mark Sanders: How does the recovery advocate aspire to such heroism?

Bill White: There is a purity—perhaps even a nobility—to recovery advocacy when it meets the heroism criteria. There is a zone of service and connection to community within advocacy work, and I think we must do a regular gut check to make sure we remain within that zone and not drift into advocacy as an assertion of ego. The intensity of camera lights, the proffered microphone, and seeing our published words and images can be as intoxicating and destructive as any drug if we allow ourselves to be seduced by them. If we shift our focus from the power of the message to our power as a messenger, we risk, like Icarus of myth,

flying towards the sun and our own self-destruction. To avoid that, we have to speak as a community of recovering people and avoid becoming recovery celebrities—even on the smallest of stages. We must stay closely connected to diverse communities of recovery and speak publicly not as an individual or representative of one path of recovery, but on behalf of all people in recovery. The fact that no one is fully qualified to do that helps us maintain a sense of humility even as we embrace the very real importance of the work to be done. The spirit of anonymity—that suppression of self-centeredness—can be respected when we speak by embracing the wonderful varieties of recovery experience rather than as individuals competing for attention and superiority.

Mark Sanders: Speaking of varieties of recovery experience, methadone maintenance and other forms of medication-assisted recovery continue to carry a great deal of stigma. Even much of the recovering community does not consider those taking methadone to be in recovery. What heroics are needed here?

Bill White: This is a most interesting question. Close to a half century of scientific research on the neurobiology of opioid addiction and the relative safety and efficacy of methadone maintenance treatment (MMT) has exerted only subtle influences on how the public and helping professionals think about MMT. It has not fundamentally changed how people feel about MMT. Stigma always trumps science in arenas that have been infused with emotional vitriol. But the research on stigma may show us a way out of this dilemma. Studies to date suggest that attitudes toward medication-assisted addiction recovery are most affected by people knowing someone personally who has been aided in their recovery by medication. There was once great stigma attached to cancer; the C-word that in the early years of my life was whispered rather than spoken and only rarely so in public. That changed when hundreds of thousands of cancer survivors took to the streets and told their stories. The stigma of cancer died when we reached a point that nearly everyone knew someone personally who had survived cancer.

I suspect the same will be true of addiction, but stigma is not equally distributed across all addictions and all styles of recovery. The heroism that could be manifested in disclosing one's recovery from alcoholism requires casting off less weight than that required to declare one's recovery from heroin addiction and supporting that recovery through methadone maintenance. I can't imagine the degree of courage the latter requires. Lisa Mojer-Torres and others broke the glass ceiling of medication-assisted recovery, and I think a day will come sooner than any of us could predict when a larger vanguard of people in medication-assisted recovery will step forward to acknowledge their existence and advocate the legitimacy of medication-assisted recovery through the stories of their lives. As it turns out, the greatest antidote to stigma is not science, but personal stories of persons with whom we can identify. The areas of greatest stigma require the greatest acts of heroism to counter.

The Value of Heroism and Recovery

Mark Sanders: Why is heroism so important in the context of addiction recovery?

Bill White: I think heroic acts in recovery—those meeting the criteria we have discussed—can do two things. At a personal level, there is the paradox that such acts can serve as an antidote to the narcissism that is an integral component of addiction, but this antidote does not work if consciously sought for that purpose. The moment heroic acts are sought for personal gain—for their therapeutic value—the antidote ceases to work and the acts no longer qualify as heroic. At a social and cultural level, heroic acts by people in recovery, and particularly by people in recovery acting in concert, challenge and break down the myths and misconceptions that feed our demonization as a people and the criminalization of AOD problems. The essential problem is that

people who personify addiction and its worst manifestations achieve great cultural visibility through every media outlet, but the mass of people who could personify long-term recovery and what recovery gives back to the community have remained culturally invisible. The heroism of going public with one's recovery at great personal risk and for the benefit of others when that status could remain hidden is what shatters stereotypes and stigma, particularly when that act also involves larger acts of service to the community.

Imagine the dilemma First Lady Betty Ford faced following her treatment for alcohol and drug dependence. Imagine the pressure to hide this experience and her treatment and her recovery status. Mrs. Ford's subsequent public disclosure was the penultimate of recovery heroism—an act that set the stage for much greater acts of service in the years that followed. In that act, Mrs. Ford saved thousands, if not tens of thousands, of lives and challenged every prevailing stereotype that then existed about addiction and recovery—particularly addiction and recovery among women. In September 2012, more than 100,000 people in recovery with their families and friends marched in recovery celebration events across the United States. That would not have been possible if Mrs. Ford had not stepped into the public light as a recovering person in the spring of 1978. And her act might not have been possible but for the courage of 52 other prominent Americans who stepped forward in 1976 as part of the National Council of Alcoholism's Operation Understanding to declare their long-term recovery from alcoholism. The risks taken by those 52 might not have been possible without the individuals before them who understood that cultural policies on alcoholism change not from scientific proof but from living proof—the personal stories of people in long-term recovery. Mrs. Ford's heroism can be historically linked to the earlier recovery disclosures of women like Lillian Roth, Mercedes McCambridge, and Marty Mann. Recovery heroism fertilizes the soil from which even greater acts of heroism rise.

The "Heroic Imagination"

Mark Sanders: You once mentioned to me that the other valuable idea drawn from the work of Franco, Blau, and Zimbardo is their concept of "heroic imagination." Where does this fit into this discussion we've been having?

Bill White: Franco, Blau, and Zimbardo, in several of their papers, asked the question whether heroism was an innate trait or something that could be cultivated in many people. They answered that it was the latter and that heroic actions could be increased by instilling what they called "heroic imagination" in a citizenry. They suggest this can be done by helping people imagine themselves facing physically or socially risky situations, struggle with the difficult decisions posed by such situations, and visualize themselves acting heroically. This can be thought of as a type of preparatory rehearsal for heroism. Franco and colleagues describe it as follows:

> *…the idea of "heroic imagination," can be seen as mind-set, a collection of attitudes about helping others in need, beginning with caring for others in compassionate ways, but also moving toward willingness to sacrifice or take risks on behalf of others or in defense of a moral cause.* (Franco, Blau, & Zimbardo, 2011, p. 102)

Mark Sanders: What would such rehearsal look like for recovery advocates?

Bill White: Perhaps it would be possible to include in the training of recovery advocates these criteria for heroism, present them with critical incidents that can arise in recovery advocacy work, and help them distinguish between heroic and unheroic styles of responding to such situations. We all enter recovery advocacy work for different reasons, but there is no reason we could not be trained and supervised to elicit the best rather than the worst within us as we pursue this special category of service work.

Heroism is not an innate and fixed characteristic. People can be heroic in one situation and not in another, and heroism can come from the most unlikely sources. Heroic acts emanating from communities of recovery could be increased by integrating this concept of heroic imagination into the training of recovery advocates. Heroism, like muscles, requires regular exercise for its development and to prevent atrophy.

Toward a Recovery Corps

Mark Sanders: Heroism is usually thought of in highly individualistic terms. What about collective acts of heroism?

Bill White: Such acts fill the annals of military history, but they can also be seen within civilian communities, particularly within some of our modern social movements. It is hard to imagine anything more heroic than the freedom riders of the early U.S. civil rights movements and the men, women, and children of that era marching into the face of fire hoses, police dogs, and police batons. Great physical and social risks also accompanied the first people who escaped their closeted status by publically acknowledging themselves as gay, lesbian, bi-sexual, or transgender people. There are parallels between that kind of collective heroism and what is unfolding within the new recovery advocacy movement. The earliest vanguards of such movements often reflect that heroic spirit.

Mark Sanders: Do you think people in recovery—as a people—have a special duty to act heroically as a community?

Bill White: I do and for two quite different reasons. First, attitudes toward addiction and addiction recovery and a host of ill-conceived practices (e.g., mass incarcerations, the long history of harmful treatments, financial exploitation, and numerous forms of discrimination) are not going to change until a vanguard of people in recovery step forward in communities across the country to put a face and voice on long-term addiction recovery. Collective action to change those circumstances may involve a collective self-interest, but there are acts of individual and collective heroism within that larger movement that deserve acknowledgement. I mentioned that last month, more than 100,000 people in recovery marched in recovery celebration events across the United States, but imagine the experience of the small number of people that first marched down the streets of those cities more than a decade ago publically identifying themselves as individuals and families in addiction recovery. The social risk is reduced but not eliminated when we stand together in large numbers as a community. Those early recovery celebration events were definitely a form of collective heroism.

In the above case, the duty to act flows from the collective needs of a group of people, but another and maybe an ever more important need for heroic action by people in recovery is that as a people we carry the weight of many transgressions against others and against our communities. Let's ask ourselves, "Are there collective sins as a recovery community that we must atone for? Do all of the amends that cannot be made for our individual transgressions constitute a debt that we as a community must repay in some form? Do we share responsibility as a community to rebalance the scales of justice?" I believe the growing activism and service work (outside of that done within the recovery fellowships) would suggest affirmative responses to these questions. When people in recovery act collectively to help heal the wounds of their communities, it serves as a form of restitution or reparations for the injuries addiction inflicts on those same communities.

Not all we do as individuals or groups of people in recovery to repay those debts will come close to the level of heroic action, but some may well reach that level. Two examples come to mind. In the immediate aftermath of the World Trade Center attacks and the days following Hurricane Katrina's assault on the City of New Orleans and the wider Gulf Coast, individuals in recovery quickly acted, alone and in concert, to

respond to the suffering that followed these events. They did it spontaneously, immediately, and effectively, deflecting any proffered public recognition of their service. On other days, groups of people—some wearing T-shirts reading "Amends in Action"—can be found reaching out to addicts still suffering, cleaning up neighborhoods, or volunteering as a group for Habitat for Humanity. Now such acts can easily be christened altruistic, but there are moments of risk and service within such collective actions that shift their status from the altruistic to the heroic.

Mark Sanders: Do you see such acts of collective heroism in the recovery community increasing?

Bill White: Yes. We may well see the emergence of something like a national Recovery Corps, modeled on the Peace Corps, through which people in recovery will serve as a healing and revitalizing force within local communities. If that happens, an increasing number of people in recovery will find ways to return home and complete their recovery journeys.

References

Blau, K., Franco, Z., & Zimbardo, P. (2012). Fostering the heroic imagination: An ancient ideal and a modern vision. *Psi Chi Journal*. Accessed October 20, 2012 at www.psichi.org/Pubs/Articles_745.aspx

Franco, Z. E., Blau, K., & Zimbardo, P. G. (2011). Heroism: A conceptual analysis and differentiation between heroic action and altruism. *Review of General Psychology*, *15*(2), 99-113.

Franco, Z., Pamlin, D., Langdon, M., Blau, K., & Zimbardo, P. (No Date*). Is Lei Feng still a modern hero?: A consideration of heroic action in the context of culture*. Unpublished paper.

Franco, Z., & Zimbardo, P. (2006-7). The banality of heroism. *Greater Good—The Science of a Meaningful Life*, Fall/Winter. Accessed October 20 at www.greatergood.berkely.edu/article/item/_banality_of_heroism

White, W. (2001a). Recovery as heroic journey. *Perspectives: A Journal on Addiction Research and Public Policy, 12*(3), 2-5 & *Recover Magazine,* 2004, *4*(3), 18-21. Posted at www.williamwhitepapers.com

White, W. (2001b). The boon of recovery. *Perspectives: A Journal on Addiction Research and Public Policy, 12*(4),2-5 & *Recover Magazine,* 2004, *4*(4), 18-21. Posted at www.williamwhitepapers.com



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. L. (2013). Myths to recover by. Posted at www.williamwhitepapers.com

Myths to Recover By

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

There are many bodies of literature that people in addiction recovery and their families and caregivers can draw upon for understanding and guidance. These include autobiographies, religious texts, self-help literature, scientific studies and clinical reports, but there are other less obvious sources that can serve as instruments of illumination and catalysts of personal transformation. I have long been fascinated with the ancient myths and fables of Native America, Greece, Rome, Africa, and Asia. It is difficult for me to read the classic myths and fables or the stories drawn from the great religions without seeing these through the lens of addiction and recovery. Consider the lessons imbedded in the stories of the following mythical figures.

Curse of Icarus

Daedalus and his Son Icarus were imprisoned by King Minos of Crete within the Labyrinth that Daedalus had built for the King. To escape, Daedalus constructed a set of wings for he and his son Icarus that were made from feathers attached with wax to a wood platform. Daedalus cautioned his son not to fly too close to the sun, but upon escaping and intoxicated with his power of flight, Icarus ignored his father's warnings and flew too high. When the wax melted, Icarus plunged to his death into the sea that today bears his name. The story of Icarus is a morality tale about the virtue of moderation and the danger of excess. It is an admonition about the importance of limitations.

Addiction is at its core a disorder of excess. The cells and the psyche scream in harmony, "higher, higher, ever higher," fueling flights that, like Icarus, many addicts do not survive. The Icarus story is a story about self-intoxication—"self-will run riot" as AA co-founder Dr. Robert Smith characterized it. Addiction for many is not just about a drug, but a broad pattern of excessive behaviors that touches most areas of one's life. So where does that leave the modern day Icarus? There are really only three broad choices. One is to succumb to the voices, ever pushing the boundary toward death and a life of crashing consequences and devastation to self, family, and community. The second is to stem this propensity for excess through self-talk (personal mantras of moderation) and by developing daily rituals of moderation in one's life as antidotes to this drive toward

excess. The final option is to channel this propensity for excess into areas that are less destructive. This final option can bring unanticipated rewards. The addict's capacity for self-destruction is matched only by his or her potential capacity for creative contribution. Both may spring from the same source—this zeal for excess that can be expressed in infamy or greatness. A good lesson: the excess that has caused us so much pain can be transformed into a virtue when properly channeled.

Narcissus Revisited

Narcissus was a beautiful youth who rejected the attentions of all. One shunned maiden prayed that Narcissus would one day experience what it felt like to be wounded by unfulfilled love. Hearing her prayer, a goddess condemned Narcissus to fall in love with his own image seen on the surface of a clear pond as he drank. He finally recognized that the image he so loved was himself and that this was a love that could never be possessed. Tormented, Narcissus plunged a knife into himself, the blood seeping into the soil and giving rise to the flower that today bears his name.

The myth of Narcissus captures the absorption with self that is so central to the experience of addiction. Manifested in self-centeredness, self-aggrandizement, self-hatred, self-pity, and above all self-encapsulization, addiction brings a strange sense of social alienation and isolation that leaves one feeling terminally unique. Addiction is above all a disease of disconnection—a disorder some feel is rooted in problems of attachment and that all agree erodes authentic intimate and social connections. For those who view the core of addiction as that of the wounded self, the antidote seems to be a process of getting into oneself through various forms of therapy and personal development activities. Entire industries—books, tapes, videos, workshops, therapists, and gurus of all flavors—flourish in their promises to help this "getting into oneself" process.

Interestingly, addiction recovery through Twelve Step programs provides a fundamentally different approach to Narcissus—the "destruction of self-centeredness." That approach is not to get further into oneself (although it includes some intermediary steps that do just that), but to connect with resources and relationships BEYOND the self. Twelve Step programs are at heart about breaking out of the narcissistic shell. The language of the Steps is not a language of "I and my" but a language of "we and our." Twelve Step programs are about mutual identification, repairing past relationships, forging new authentic relationships, forging a relationship with a "power greater than myself," and service to others. In the view of AA, NA, and other Twelve Step Programs (and many faith-based pathways to recovery), the ultimate antidote for Narcissus is not getting deeper into oneself, but getting out of oneself.

The Redemption of Sisyphus

Sisyphus, the son of King Aeolus, was a trickster known for his cleverness and deceitfulness, particularly his seduction and harm of the innocent. When ordered to be chained for revealing secrets of the gods, Sisyphus tricked Thanatos, death's messenger, into shackling himself, which granted humans immortality until Thanatos was freed. After Sisyphus refused to die and remain in the underworld, Zeus created a unique punishment. For eternity, Sisyphus would be driven to repeatedly roll a large stone up a steep mountain only to have the stone roll back down as it neared the top.

There is much in the persona of Sisyphus that reflects addiction-related transformations of personal character—the dishonesty, the manipulation, the disregard and injury of others, and who could not recognize in Sisyphus' repetitive attempt to get the stone to the top of the mountain the addict's compulsive attempt to gain mastery over his or her drug consumption. One can actually imagine Sisyphus' thoughts and promises as he re-enacts each climb: *This time will be different. I just need one more chance. I will stop after this one last effort*. Sisyphus and the addict share the

frustration, futility, and ultimate absurdity of trying to achieve an impossible task but being unable to give up trying.

So how is Sisyphus to be redeemed? There are millions of people in the world today who achieved recovery by the simplest of acts: walking away from the mountain. Their exit marked both the abandonment of the Sisyphean effort at drug control and their escape from the culture of addiction—the people, places, and things that embraced the rituals of drug use. If the mountain and the endless ritual of stone rolling stand as metaphors for addiction, then several key questions can serve as a form of daily self-inventory.

1) Do I reaffirm today that all efforts to regain control over alcohol and drug use would be futile?
2) What actions can I take today to maintain my physical and emotional distance from the mountain?
3) What stones other than my past efforts at drug control do I continue to push up the proverbial mountain?
4) If I am to truly leave my life on the mountain, what am I doing today to build and embrace a new home and a new life?

The paradox in the Sisyphus story is that one wins the struggle for control by abandoning the effort—experiencing power through the acknowledgment of powerlessness. The mountain and its endlessly repeated ritual constitute forms of imprisonment in which the cell door has always been unlocked. All you ever had to do was open the door and leave. Release and recovery are first and foremost a shift within one's own mind and a turning and walking away. In retrospect, it was so difficult and yet so simple.

Prometheus Unchained

In Greek mythology, Prometheus molded humans from clay and served as humankind's advocate before the gods. His efforts on behalf of humans included tricking the gods to obtain the best offerings at feast for humans and then stealing and giving fire to humans. In retaliation, Zeus ordered the creation of Pandora as a curse to humans (see below) and ordered Prometheus to be chained to a stake on a mountain where his liver (or heart in some versions) would be eaten, regenerated each night, and re-eaten the next day for eternity. This punishment continued until Prometheus was freed by Hercules.

There is much in the Prometheus myth that mirrors the experience of addiction and recovery. Prometheus, like Sisyphus, is bright, clever, and rebellious—traits that have often been linked to addicts. The nature of Prometheus' punishment also resounds of the addiction experience: the image of restricted freedom and being bound, having one's liver and heart attacked only to regenerate and be attacked again, and the inability of Prometheus to free himself solely with his own strength and resources. While one yearns to see Prometheus breaking free from his bonds, it is only with assistance that his freedom is achieved, confirming the recovery folk wisdom that "you can do it, but you can't do it alone." That the source freeing Prometheus was Hercules suggests the need for great power to free one from the state of addiction.

The Heel of Achilles

Achilles is a heroic yet tragic figure in Greek mythology. He was the principle character in Homer's Iliad and the great warrior of the Trojan War. Legend has it that Achilles' mother sought to make him immortal by dipping him in the Styx River. His body was invulnerable except for that small portion where she had held him—his heel. It was thus a small wound on his heel from an arrow shot by Paris that later led to the death of Achilles. The phrase "Achilles' heel" has since been used to refer to the source of a person's vulnerability.

AA historian Ernest Kurtz has suggested through his writings that the acceptance of imperfection—accepting that

one is “Not-God”—is at the very core of AA spirituality. Such acceptance requires knowledge and acknowledgement of the precise nature of that imperfection. Not taking the next drink in AA parlance and in professional models of “relapse prevention” requires knowing and protecting one’s Achilles’ heel. Such vulnerabilities can be rooted in certain physical and emotional states, certain patterns of thinking or in encounters with particular “people, places, and things” that reawaken the sleeping dragon within. The lesson of Achilles is that we must remain vigilant in protecting the points of our greatest vulnerability.

Addiction’s Siren Songs

Sirens, as portrayed in Greek mythology, were sister seductresses—each half woman, half bird—whose beautiful voices lured unsuspecting passing sailors to crash their boats on the rocky reefs of the island on which the sirens resided. It is said that Odysseus escaped this fate in passing the Sirens’ island only by plugging his men’s ears with beeswax and ordering himself tied to the mast of his ship as they passed the island. Siren song has since come to mean the sweet voices of temptation that draw one toward personal disaster.

For centuries, people in recovery have personified addiction as beasts, dragons, and devils whose inviting voices must be resisted. In AA traditions, such self-talk has been castigated as “stinkin’ thinkin’” and early NA members referred to such thoughts as “needling oneself”. Christian recovery literature similarly warns of the Devil’s voice, and secular recovery literature is filled with reference to the “Pavlovian Pull” (Christopher, 1988) and to the amplified voice of “the beast” (Trimpey, 1989). Put simply, addiction is often fueled by a pattern of self-talk whose troubling presence can continue long into the recovery process. Recovery is in part about changing how we talk to ourselves.

The Lure of Pandora’s Box

In the mythology of ancient Greece, Zeus, the supreme god, sent his daughter Pandora to earth to marry Epimetheus along with the gift of a mysterious box that came with the admonition that it could never be opened. It was perhaps inevitable that a day would come when the lure of the box would become irresistible. When Pandora opened the lid of the box, all of the evils known to humankind quickly escaped from the box. “Opening Pandora’s box” has since stood as a warning that some things are best left unexplored. But wait, the Pandora story as popularly recounted is incomplete. Once the evils had escaped from the box, one thing was remaining that Pandora removed from the box—Hope.

There are of course many ways this story could be explored in the context of addiction and recovery, but I would like to offer the following. Each of us is the box of Pandora and within us resides primitive thoughts and emotions and closely guarded secrets all protected with the admonition that they cannot be released to the world. And so each of us is left with the burden of what precisely to do with this shadow side of ourselves that is so often the source of guilt and shame. We are often told that this shadow feeds our addiction: “You’re only as sick as your secrets.” Twelve Step programs—the steps of self-inventory, confession, amends, and service to others—provide a framework to address this shadow. Similarly, numerous schools of addiction psychotherapy are based on the assumption that recovery comes only through purging the hidden, distressing emotions that have long been self-medicated with drugs.

I think the myth of Pandora offers several important lessons. First is the acknowledgement of this shadow side and the parallel understanding that the good within us can only be fully discovered and valued through a path that traverses our shadow side. To become whole and healthy requires acceptance of all of who we are—Ernie Kurtz and Katherine Ketcham have referred to this as the “spirituality of imperfection.” In the Pandora story, hope

only becomes visible and accessible after the evil spirits have escaped. And so we have the peculiar situation of an illness, addiction, whose remedy involves a most unusual form of medicine: honesty with self and others. But there is a second lesson and that is the unpredictability of opening the box via the risks to self and others. Buried within the Twelve Steps are an understanding of this risk and certain limitations on disclosure of past wrongs (e.g., defining the context of disclosure and prohibiting disclosures that would do harm to others).

Releasing powerful emotions requires, like bleeding, the ability to clot—to bring emotion back under control once released. There may well be people who lack this ability to emotionally clot—a condition that could be thought of as a form of emotional hemophilia—and who would be harmed rather than helped by such release. There is also the issue of context—the degree of safety in the choice of timing and place for opening oneself in this manner. All this adds a note of caution and care about how this process is managed and the recognition that recovery for some involves not a release of emotion but mastery of how such emotion can be controlled. Like so many areas of recovery, the message, "easy does it," is quite apt.

The Procrustean Bed

Dr. John Strang recently called my attention to another mythical figure whose story will close this initial exploration of myth and recovery. Procrustes was a robber who lured visitors to his home with the promise of a magical bed that perfectly fit each person's body. Once the victim was tied to the bed, Procrustes would stretch the body if they were two short or cut off the legs if they were too tall. Ironically, Procrustes would later die by this same method. The phrase "Procrustean bed" has since referred to the act of forcing someone to conform to a fixed way of doing things.

Well, there is much food for thought here for those seeking help for an addiction. First, all of those offering you help and hospitality are not necessarily your friend. Second, when a bed doesn't fit you—whether that bed be your own methods of problem solving, a particular treatment approach, or a framework of recovery mutual aid—get out of the bed and find one that does fit you. Third, when people try to force you into a bed that does not fit, escape! And of course, for the addiction professionals among our readers: stop stretching people and cutting their legs off!

If there is anything modern research on recovery is teaching us, it is two critical lessons: people with alcohol and drug problems—even the most severe of such problems—are not a homogenous population, and there are many pathways and styles of long-term recovery. These growing varieties of recovery experience should be cause for celebration, not a trigger for defensiveness. As Professor Strang suggests, "We need to come to terms with the imperfection of any one model, and recognize that we need different-sized beds for people of different sizes."

Conclusion

What can be found in these classic myths are valuable lessons about how to achieve recovery and live a meaningful life in recovery. They convey lessons about the dangers of hubris, the value of humility, and the protection of vulnerability. They also suggest that freedom is possible, but not always achievable by oneself.

References

Christopher, J. (1988). *How to stay sober: Recovery without religion*. Buffalo, NY: Prometheus Books.

Strang, J. (1985). Breaking out of Procrustes' bedx—Services for problems of drug takers. *Bulletin of the Royal College of Psychiatrists*. 9, 150-152 (quote from page 150).

Trimpey, J. (1989). *The Small Book*. New York: Delacorte Press.



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: Best, D. Loudon, L., Powell, D. McCluskey, C., Groshkova, T and White, W. (2013). Identifying and recruiting recovery champions: Exploratory action research in Barnsley, South Yorkshire. *Journal of Groups in Addiction and Recovery*, 8(3), 169-184. Posted at www.williamwhitepapers.com

Identifying and recruiting recovery champions: Exploratory action research in Barnsley, South Yorkshire

ABSTRACT

The UK Drug Strategy has embraced the philosophy of recovery as an "individual, person-centered journey" (Her Majesty's [HM] Government, 2010, p. 19) and is supported by a local network of recovery champions. The purpose of this article is to examine proactive attempts at establishing such networks based on training and working with a mixture of people in recovery and professionals, supported by a local recovery leader. What is presented in this article is a case study of an initiative attempting to access and link recovery champions. The early stages of the initiative were planned in advance, but the later stages were evolutionary and were based on the decisions of the emerging recovery champions group. The initiative started with a series of workshops to raise awareness about recovery, and from this, to recruit an initial group of candidate champions. Small groups were successfully recruited to participate in subsequent champions workshops, and they have since translated that commitment to a range of actions and directions, which have attempted to generate a visible recovery community and to challenge stereotypes and stigma perceptions. The final section of the article will review the utility of the label of "recovery champion" and will examine the role of such networks in enabling and supporting the emergence of a local culture of recovery.

For Full text, see http://www.tandfonline.com/doi/full/10.1080/1556035X.2013.785209



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. L. & Evans, A.C. (2013). Toward a core recovery-focused knowledge base for addiction professionals and recovery support specialists. Posted at www.williamwhitepapers.com

Toward a Core Recovery-focused Knowledge Base for Addiction Professionals and Recovery Support Specialists

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Arthur C. Evans, Jr., PhD
Commissioner
Philadelphia Department of Behavioral Health and Intellectual disAbilities Services

Recovery is emerging as a new organizing construct within the alcohol and drug problems arena. Government policymakers are reframing policy goals beyond those of supply reduction, harm minimization, and demand reduction. Discussions of primary prevention, early intervention, and clinical treatment are being reframed within a larger rubric of personal, family, and community recovery; wellness; and quality of life. Acute and palliative care models of addiction treatment are giving way to models of sustained recovery management nested within larger recovery-oriented systems of care. Clinical assessment and service planning are being revolutionized via the constructs of recovery capital and recovery planning. Multiple pathways of long-term recovery are being mapped within and across an ever-growing network of religious, spiritual, and secular recovery mutual aid societies and a greater understanding of processes of natural recovery. Grassroots recovery community organizations are springing up across the globe in an unprecedented level of cultural and political mobilization of individuals and families in recovery. New service institutions are emerging—recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes—that do not fit the traditional categories of addiction treatment and recovery mutual aid. Internet-based and other technology-based mutual aid and social networking are challenging traditional mechanisms for delivering both treatment and recovery support. New recovery-focused service roles are rapidly spreading, e.g., recovery support specialists, recovery coaches, peer specialists. And calls for pursuit of a recovery-focused research agenda are challenging the historical addiction pathology preoccupations of the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

Support for recovery as an organizing paradigm has not been universal. Critics representing diverse interests have contended to the authors that the recovery concept is amorphous ("Is it like pornography? You can't define it but you know it when you see it?"), redundant ("We're already recovery-oriented."), faddish ("a flavor of the month"), unscientific ("Are there evidence-based recovery practices?"), impractical ("No one will fund long-term recovery support."), and dangerous ("Recovery is a political Trojan horse whose real aim is de-professionalizing, delegitimizing, and defunding science-based addiction treatment and harm reduction services" (also see Davidson et al., 2005; Kirk, 2011). Each of these critiques must be challenged if recovery is to prove and sustain its value as a governing vision for the field. The authors have argued in a long series of papers, monographs, books and professional presentations that a true long-term recovery orientation will require a radical transformation of how addiction treatment and recovery support services are planned, designed, delivered, and evaluated (For a synthesis of these, see White, 2008a). But recovery's life expectancy as an organizing construct could indeed be limited if recovery and recovery-oriented practices remain ill-defined or if the recovery concept is hijacked and its meaning diluted or distorted to protect prevailing ideologies and institutional interests.

The next stage of the "recovery revolution," if it is to really be that, is to define in extremely concrete terms what recovery is and is not, how recovery orientation changes prevailing practices in addiction treatment, how new recovery roles differ from the service roles that preceded them, and what recovery-focused benchmarks should be used to evaluate role performance, organizational performance and systems performance. The present paper is part of a series of papers through which the authors wishes to contribute to this definitional work. The focus of the present paper is the following question:

Is there a core recovery-focused knowledge and skill set that distinguishes recovery-oriented addiction treatment and long-term recovery support services?

Table 1 below compares core areas of knowledge and skill that have constituted the historical education and training of traditional addiction professionals with core areas of knowledge and skill the author believes constitute an essential foundation for the delivery of recovery-oriented care and support. The first column of Table 1 represents topical areas addressed through mainstream addiction research activities, the curricula of addiction studies and addiction counselor training programs, addiction professional certification and licensure program standards, and the knowledge and skill sets used to screen, hire, train, and supervise addiction treatment professionals. This specialty knowledge is well-illustrated in publications such as the Center for Substance Abuse Treatment's Tap 21: *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*.

The second column of Table 1 notes recovery-focused ingredients that have been missing and that would need to be addressed in any move to increase the field's recovery orientation. The citations in column two illustrate publications that have attempted to address some of these historically neglected areas. These citations are not intended to be comprehensive but rather are included to illustrate that there are starting points on which to build this recovery-focused knowledge and skill base.

It is our contention that the core knowledge and skills outlined in column two constitute essential aspects of what should be included in the education, training, and ongoing supervision of all addiction treatment and recovery support specialists. Much of the recommended knowledge base does not currently exist and will not exist until federal, state and private research agendas are expanded to include critical recovery-focused questions. However, as the citations in column two suggest, sufficient knowledge

is available to begin this shift toward more recovery-focused training of addiction professionals and recovery support specialists.

Table 1: Contrasting Pathology-focused Medical/Clinical Paradigms and a Recovery Paradigm of Education and Training of Addiction Professionals and Recovery Support Specialists

Present Education/Training Focus	Missing Recovery Dimensions
Ways of knowing (scientific, professional, clinical knowledge); credibility and status based on educational, professional, organizational credentials/titles. Affirmation of the power and importance of science. Resources for accessing addiction-related research and literature.	Ways of knowing (experiential knowledge Borkman, 1976; Jackson, 2001, and cultural knowledge, Brady, 1995); credibility and status based on personal story/character and vetting as a healer via the community "wire"—a paperless credential no academic institution or professional certification body can bestow (White & Sanders, 2008). Acknowledgement of the limitations of science. Resources for accessing indigenous institutions and healers and experience-based and culturally-grounded recovery literature.
Problem definition, e.g., addiction & its defining elements; diagnostic criteria, e.g., APA DSM-V, WHO ICD-10.	Solution definition, e.g., personal/family/community resilience, resistance, & recovery & their defining elements (Betty Ford Institute Consensus Panel, 2007; Laudet, 2007; White, 2007; McLellan, 2010; SAMHSA, 2009, 2011; United Kingdom Drug Policy Commission, 2008); recovery measurement tools, e.g., paucity of validated DSM/ASI counterparts for assessing recovery status, stage of recovery, & recovery support needs.
Emphasis on assessment of problem severity/complexity (dozens of screening and assessment instruments, e.g., ASI, AUDIT, CAGE, CRAFFT, DAST, DUSI-R, GAIN, MAST, SCID) and models for level of care placement.	Emphasis on, but paucity of, instruments for assessment of personal, family, & community recovery capital (Groshkova, Best, & White, 2012; White & Cloud, 2008).

Present Education/Training Focus	Missing Recovery Dimensions
History of drug use/addiction & history of addiction treatment as a cultural institution.	History of addiction recovery, including modern diversification of recovery mutual aid organizations, the new recovery advocacy movement, growth of grassroots recovery community organizations and other new recovery support institutions (e.g., recovery homes, recovery schools, recovery industries, recovery ministries, recovery community centers, recovery cafes, recovery activities in sports, music, theatre, film) and technology-based recovery support resources (e.g., Internet-based mutual aid and recovery-supportive social networking; smart phone applications for recovery support; Humphreys, 2004; Kelly & White, 2012; For extensive citations, see White, 1998; 2000a, 2000b; 2001, 2004, 2006, 2007, 2009; White, Kelly, & Roth, 2012).
Pharmacology of drugs/neurobiology of addiction. Medical aspects of addiction, e.g., relationship between addiction and disease.	Neurobiology of addiction recovery (Erickson & White, 2009), pharmacology of medications used within addiction treatment (Abraham et al., 2009; Edwards et al., 2011; Garbutt, 2009; Knudsen et al., 2011; Rieckmann et al., 2007; White, Parrino, & Ginter, 2011), & medical aspects of recovery (temporal norms related to renormalization of sleep, energy, appetite, cognitive functioning, sexual functioning, and improvement/alleviation of addiction-related health problems, e.g., van Eijk, et al, 2012). Relationship between recovery and health.
AOD-related problem prevalence—review of community AOD use prevalence surveys (e.g., Monitoring the Future; National Household Survey); patterns of substance use drawn from national data systems profiling persons entering addiction treatment (e.g., SAMHSA—TEDS); other AOD-related casualty data, e.g., death data, arrest data, ER admissions, social cost data, etc.; this near-exclusive focus on problem prevalence and severity contributes to stigma-laden stereotypes of addiction and fuels cultural and therapeutic pessimism about the achievement of long-term recovery.	Solution prevalence—remission/recovery prevalence patterns drawn from community and clinical population surveys; profiles of people in recovery by demographics, primary drug(s); special populations, e.g., veterans, persons with co-occurring medical & psychiatric disorders; health profile/needs of people in recovery; community contribution profile of people in recovery via employment, income/taxes, service, etc. (Dawson, 1996, 1998; Dawson et al., 2005, 2006a, 2006b, 2007, 2008; ; Kessler et al., 1994, 2005; White, 2012); Emphasizing solution prevalence data raises cultural optimism and personal/family hope for recovery.

Present Education/Training Focus	Missing Recovery Dimensions
Pathology & intervention paradigms—theories of addiction; models of addiction treatment and theories of counseling; emphasis on the psychology of addiction & role of professional treatment in recovery initiation. Presentation of harm reduction (HR)models (theory and representative programs) as an alternative to addiction treatment and recovery support	Recovery as an organizing paradigm (Berridge, 2012; El-Guebaly, 2012; Elise, 1999; Morgan, 1996; White, 2004, 2005, 2008; Zweben, 1986); theories of recovery (Biernacki, 1986; Frykholm, 1985; Klingemann, 1991; Prochaska et al., 1994; Waldorf, 1983; Waldorf et al., 1991; White, 1996). Models integrating HR with treatment and recovery within an addiction / treatment / recovery careers schema (see Dennis, Scott, Funk, et al, 2005; Hser, Anglin, Grella, et al, 1997; Kellogg, 2003; Kellogg & Kreek, 2005; Marlatt, Blume & Parks, 2001; McLellan, 2003).
Short-term expert relational model—focus on brief hierarchical relational model drawn from brief psychotherapy role practiced by psychiatrists, psychologists, and social workers; emphasis on maintaining power differential and professional distance; rigorous boundary maintenance; prohibition on dual relationships; discouragement of self-disclosure.	Long-term partnership relational model; emphasis on system-wide relationships built on moral equality and emotional authenticity; reduced power differential; and value of recovery support relationships that are natural, non-hierarchical, reciprocal, enduring, and non-commercialized (White, 2008a; Lamb, Evans, & White, 2009).
Emphasis on treatment/recovery as a process of incremental change (e.g., stages of change and use of motivational interviewing to enhance recovery initiation); assertion of addiction as a "chronic, progressive, relapsing disorder"; relapse portrayed as part of recovery; focus on relapse prevention and relapse management.	Potential for recovery as a process of transformational change that is sudden, unplanned, positive, and permanent (Miller & C' de Baca, 2001; White, 2004); any resumption of AOD use and related problems is viewed, not as part of the recovery process, but as part of the pathology of addiction (White, 2010); recovery prevalence data collected includes emphasis on the number of people in continuous recovery since their first recovery initiation; focus on recovery maintenance and enhanced quality of personal and family life in long-term recovery (Laudet, Becker, & White, 2009).

Present Education/Training Focus	Missing Recovery Dimensions
Techniques of individual, group, and family counseling that focus on enhancing autonomy and individuation, self-knowledge, self-development, self-assertion, self-control, self-confidence, and self-esteem ("treatment as a process of getting into oneself"), e.g., self is the solution. Emphasis on listening.	Recovery-focused reconstruction of identity, character, values, and relationships (White, 1996); recovery as spiritual self-transcendence, mutual dependence, humility, tolerance, respect, and service to others ("recovery as a process of getting out of oneself"; Kurtz & Ketcham, 1992), e.g., self ("I") is the problem; "we" is the solution. Emphasis on storytelling and power of mutual identification.
Idiopathic, person-focused perspectives on etiology of AOD problems & their resolution. Stages of substance use disorders (pathways of problem entry).	Ecological (historical, cultural, economic, and political perspectives on the etiology of AOD problems & their resolution (White & Sanders, 2008). Integration of clinical and cultural revitalization/community development perspectives, including techniques for engaging indigenous community leaders, mapping recovery community resources, mobilizing untapped recovery community resources, and hosting recovery celebration events; strategies and tactics for recovery-focused community education and pro-recovery policy advocacy (Johnson, Martin, Sheahan, Way, & White, 2009; Maguire, Sheahan, & White, 2011). Pathways, processes, styles, and stages of long-term addiction recovery (pathways of problem exit; See White & Kurtz, 2006b for a review).
Emphasis on role of personal, organizational, and professional characteristics in predicting short-term treatment outcomes.	Emphasis on role of family and social environment, community culture, and community recovery capital in predicting long-term recovery outcomes (Humphreys, Moos, & Cohen, 1997).
Pathological family adaptations to progression of addiction (encompassing whole system, family subsystems, and individual family members).	Family (as system, subsystems, and individuals) adaptations across stages of long-term recovery, including adaptations to what Brown & Lewis depicted as the "trauma of recovery" (Brown & Lewis, 1999; White & Savage, 2005).

Present Education/Training Focus	Missing Recovery Dimensions
Professionally directed treatment planning; growing emphasis on coercion, control, and compliance.	Person-directed recovery planning (Borkman, 1998); emphasis on role of choice in recovery and personal inclusion in decision-making related to recovery support needs (White, 2008b).
Cultures of addiction (limited review of peer influence on addiction initiation and maintenance within drug subcultures)	Cultures of recovery (White, 1996); emphasis on status and studies of contemporary indigenous recovery support institutions; review of how recovery experience is being expressed through pathway-specific and ecumenical cultures of recovery via symbols, rituals, language, values, art, film, theatre, internet-based social networking, music, sport, literature, history, and community service (White, 2008b, also see following sections at www.williamwhitepapers.com : Recovery Support Interviews, History of Recovery Mutual Aid, and Varieties of Recovery Experience.)
Techniques to support acute biopsychosocial stabilization, e.g., crisis intervention; detoxification; brief sequestration from culture of addiction; addiction-focused psychosocial education; short-term individual, group, and family counseling; orientation and encouragement for recovery mutual aid involvement; review of studies of AA and other recovery mutual aid on short-term outcomes of persons completing addiction treatment.	Techniques to support long-term personal/family recovery, e.g., emphasis on techniques for post-treatment monitoring, stage-appropriate recovery education; recovery support, and if and when needed, early re-intervention; emphasis on role of community in long-term recovery and potential role addiction professionals can play in later stages of personal/family recovery (Chi et al., 2011; Dennis, Scott, Funk, et al, 2005, 2012; Godley et al., 2007; McKay et al., 2004, 2005a,b, 2011; White, 2009); Review of studies of AA and other recovery mutual aid on long-term outcomes of treated and untreated populations (For reviews see, Kelly & Yeterian, 2008; White, 2009).

Present Education/Training Focus	Missing Recovery Dimensions
Role and risks of medications in addiction treatment and recovery.	Risks and benefits of medication in recovery initiation and long-term recovery maintenance (White & Torres, 2010); evolving attitudes of addiction professionals and recovery mutual aid groups toward medications in general and the pharmacotherapeutic treatment of opioid addiction in particular (See White, 2011; White, Parrino, & Ginter, 2011 for extensive citations); alternative recovery support structures for Opioid Treatment Program patients (Ginter, 2012).
Vulnerability of, and predictive risk factors for, "special populations"—women, youth, elderly, people of color, LGBT, people with co-occurring disorders, etc.	Resilience, resistance, and recovery of historically disempowered populations; presence of indigenous recovery capital within historically marginalized persons and communities (Coyhis & White, 2006).
Influence of patient cultural affiliation and personal/historical trauma on addiction & the counseling process.	Culturally indigenous pathways of long-term recovery across the life cycle; emphasis on potential for resistance (abstinence as a an act of cultural/political activism and personal/cultural survival), recovery, and resilience in the face of personal & historical trauma (Brave Heart, 2003; Brave Heart & DeBruyn, 1998; Brave Heart et al., 2011; Coyhis & White, 2006; Williams, with Laird, 1992).
Addiction/Treatment-focused patient, professional, and community education.	Recovery-focused patient, professional, and community education (White, 2001); stigma management as a critical recovery component for individuals, families, and communities (White & Torres, 2010).
Legal and ethical issues in addiction counseling; ethical values drawn from professional community, with emphasis on confidentiality and maintaining professional detachment—*appropriate boundary management*.	Cultural etiquette of working with diverse communities of recovery across diverse cultural contexts (Achara-Abrahams et al., 2012; White & Kurtz, 2006a; White & Sanders, 2008; White, Evans, Lamb, & Achara-Abrahams, in press); ethical values and cultural etiquette drawn from multiple communities of recovery—with emphasis on humility, love, service, discretion, and respect; knowledge of anonymity tradition and its multiple functions.

Present Education/Training Focus	Missing Recovery Dimensions
Interagency collaboration; emphasis on mechanics and etiquette of working with formal community institutions, e.g., key organizations, roles, procedures, language.	Collaboration with & assertive linkage procedures to recovery mutual aid organizations and rapidly expanding recovery community organizations, e.g. key organizations, roles, procedures, language.,; knowledge and skills in developing and mobilizing community recovery support resources (Humphreys, 1999; Kaskutas, Subbaraman, Witbrodt, & Zemore, 2009; McKnight, 1995; Timko, DeBenedetti, & Billow, 2006; White, 2001, 2009; White & Kurtz, 2006; Williams & Laird, 1992).
Focus on Short-term Treatment Outcomes; role of addiction professional in primary treatment.	Focus on long-term recovery outcomes (White, 2012); role of addiction professional and recovery support specialists across the stages of recovery (White, 2006).
Frequent note of intergenerational transmission of AOD problems.	Discussion of potential role of recovery in breaking intergenerational cycles and parenting strategies for recovering parents that can reduce risks of AOD problems in their children (Arria et.al., in press; White & Chaney, 2012).

The above table is not meant to suggest opposing, mutually exclusive bodies of knowledge. It is instead a way to convey that we as a field have developed great expertise on alcohol and other drug-related problems, but lack a comparable body of knowledge related to the solutions to these problems as they exist today in the lives of individuals, families, and communities. It is time we moved beyond the superficial rhetoric calling for increased recovery orientation in the design of addiction treatment (and community-based recovery support services) and began the much harder work of building and then infusing a recovery-focused foundation of knowledge and skills into the education and training of addiction professionals, recovery support specialists and the broader arena of allied health and human service professionals. Work towards that goal is already underway.

About the Authors: William White is Emeritus Senior Research Consultant, Chestnut Health Systems; Arthur C. Evans, Jr., is Commission, Philadelphia Department of Behavioral Health and Intellectual disAbility Services.

Acknowledgement: Support for this paper was provided by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, NAADAC: The Association for Addiction Professionals and 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 these organizations.

References

Abraham, A. J., Ducharme, L., & Roman, P. (2009). Counselor attitudes toward pharmacotherapies for alcohol dependence. *Journal of Studies of Alcohol and Drugs*, *70*, 628-635.

Achara-Abrahams, I., Evans, A. C., Ortiz, J., Villegas, D. L., O'Dell, J., Ali, O., & Hawkins, D. (2012). Recovery management and African Americans: A report from the field. A*lcoholism Treatment Quarterly*, *30*, 263-292. doi:10.1080/07347324.2012.691049

Arria, A. M., Mericle, A. A., Rallo, D., Moe, J., White, W. L, Winters, K. G., & O'Connor, G. O. (in press). Integration of parenting skills education and intervention in addiction treatment. *Journal of Addiction Medicine*.

Berridge, V. (2012). The rise, fall, and revival of recovery in drug policy, *Lancet*, *379*, 22-23.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. doi:10.1016/j.jsat.2007.06.001

Biernacki, P. (1986). *Pathways from heroin addiction: Recovery without treatment.* Philadelphia: Temple University Press.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review, 50*, 443-456.

Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42.

Brady, M. (1995). Culture in treatment, culture as treatment. A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science Medicine*, 41(11), 1487-1498.

Brave Heart, M. Y. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13. doi:10.1080/02791072.2003.10399988

Brave Heart, M. Y., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research and clinical considerations. *Journal of Psychoactive Drugs*, *43*(4), 282-290. doi:10.1080/02791072.2011.628913

Brave Heart, M. Y., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research Journal, 8*(2), 60-82.

Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

Center for Substance Abuse Treatment (CSAT), (2006). *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Chi, F. W., Parthasaranthy, S., Mertens, J. R., & Weisner, C. M. (2011). Continuing care and long-term substance use outcomes in managed care: Early evidence for a primary care-based model. *Psychiatric Services*, 62(10), 1194-1200. doi:10.1176/appi.ps.62.10.1194

Coyhis, D. L., & White, W. L. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research*

and Practice, 36, 480-487. doi:10.1037/0735-7028.36.5.480

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. doi:10.1111/j.1530-0277.1996.tb01685.x

Dawson, D. A. (1998). Symptoms and characteristics of individuals with different types of recovery from DSM-IV alcohol dependence. *Journal of Substance Abuse, 10,* 127-142. doi:10.1016/S0899-3289(99)80129-1

Dawson, D. A., Goldstein, R. B., & Grant, B. F. (2007). Rates and correlates of relapse among individuals in remission from DSM-IV alcohol dependence: A 3-year follow-up. *Alcoholism: Clinical and Experimental Research*, *31*(12), 2036-2045. doi:10.1111/j.1530-0277.2007.00536.x

Dawson, D. A., Grant, B. F., Stinson, F. S., & Chou, P. S. (2006). Estimating the effect of help-seeking on achieving recovery from alcohol dependence. *Addiction*, *101*, 824-834. doi:10.1111/j.1360-0443.2006.01433.x

Dawson, D. A., Grant, B. F., Stinson, F. S., & Chou, P. S. (2006). Maturing out of alcohol dependence: The impact of transitional life events. *Journal of Studies on Alcohol*, *67*, 195-203.

Dawson, D. A., Grant, B. F., Stinson, F. S., Chou, P. S., Huang, B., & Ruan, W. J. (2005). Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction*, *100*(3), 281-292. doi:10.1111/j.1360-0443.2004.00964.x

Dawson, D. A., Stinson, F. S., Chou, S. P., & Grant, B. F. (2008). Three-year changes in adult risk drinking behavior in relation to the course of alcohol-use disorders. *Journal of Studies of Alcohol and Drugs*, *69*, 866-877.

Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28,* S51-S62. doi:10.1016/j.jsat.2004.10.013

Dennis M. L., & Scott, C. K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence, 121*, 10-17. doi:10.1016/j.drugalcdep.2011.07.026

Edwards, S., Kenna, G. A., Swift, R. M., & Leggio, L. (2011). Current and promising pharmacotherapies, and novel research target areas in the treatment of alcohol dependence: A review. *Current Pharmaceutical Design*, *17*(14), 1323-1332.

El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine*, *6*(1), 1-9.

Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery, 6*(2), 11-23.

Erickson, C., & White, W. (2009). Commentary: The neurobiology of addiction recovery. *Alcoholism Treatment Quarterly*, *27*(3), 338-341.

Frykholm, B. (1985). The drug career. *Journal of Drug Issues, 15*, 333-346.

Garbutt, J. C. (2009). The state of pharmacotherapy for the treatment of alcohol dependence. *Journal of Substance Abuse Treatment*, *36*(Suppl 1), S15-S23.

Ginter, W. (2012). Methadone Anonymous and mutual support for medication-assisted recovery. *Journal of Groups in Addiction & Recovery*, 7(2-4), 189-201.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). 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. doi:10.1111/j.1360-0443.2006.01648.x

Groshkova, T, Best, D., & White, W. (2012). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review*. Advance online publication. doi: 10.1111/j.1465-3362.2012.00489.x

Hser, Y., Anglin, M., Grella, C., Longshore, D., & Prendergast, M. (1997). Drug treatment careers: A conceptual framework and existing research findings*. Journal of Substance Abuse Treatment*, 14(3), 1-16.

Humphreys, K. (1999). Professional interventions that facilitate 12-step self-help group involvement. *Alcohol Research and Health*, *23*, 93-98.

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge: Cambridge University Press.

Humphreys, K., Moos, R. J., & Cohen, C. (1997). Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol*, *58*(3), 231-238.

Jackson, S. W. (2001). The wounded healer. *Bulletin of the History of Medicine*, *75*, 1-36.

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.facesandvoicesofrecovery.org

Kaskutas L. A., Subbaraman, M. S., Witbrodt, J., & Zemore, S. E. (2009). Effectiveness of Making Alcoholics Anonymous Easier (MAAEZ): A group format 12-step facilitation approach. *Journal of Substance Abuse Treatment, 37*(3), 228-239. doi:10.1016/j.jsat.2009.01.004

Kellogg, S.H. (2003). On "Gradualism" and the building of the harm reduction-abstinence continuum. *Journal of Substance Abuse Treatment*, 25, 241-247.

Kellogg, S.H., & Kreek, M.J. (2005). Gradualism, identity, reinforcements, and change. *International Journal of Drug Policy*, 16, 369-375.

Kelly J. F., & Yeterian, J. (2008). Mutual-help groups. In W. O'Donohue & J. R. Cunningham (eds.), *Evidence-based adjunctive treatments* (pp. 61-106). New York: Elsevier.

Kelly, J. F., & White, W. (2012) Broadening the base of addiction recovery mutual aid. *Journal of Groups in Addiction & Recovery*, *7*(2-4), 82-101.

Kessler, R., McGonagle, K, Zhao, S., Nelson, C., Hughes, M., Eshelman, S.,…Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8-19.

Kessler, R. C., Chiu, W. T., Demier, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, *62*, 617-627.

Kirk, T.A. (2011). Connecticut's journey to a statewide recovery-oriented health-care system: strategies, success and challenges. In: Kelly, J.F. & White, W.L. *Addiction Recovery Management: Theory, Research and Practice*. New York: Humana Press / Springer Science. pp. 209-234.

Klingemann, H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of Addiction, 86,* 727-744.

Knudsen, H. K., Abraham, A. J., & Roman, P. M. (2011). Adoption and implementation of medicaztions in addiction treatment. *Journal of Addiction Medicine*, *5*(1), 21-27.

Kurtz, E., & Ketcham, K. (1992). *Spirituality of imperfection: Storytelling and the search for meaning.* New York: Bantam Books.

Lamb, R., Evans, A. C., & White, W. (2009). *The role of partnership in recovery-oriented systems of care: The Philadelphia experience*. Posted www.facesandvoicesofrecovery.org

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 243-256. doi:10.1016/j.jsat.2007.04.014

Laudet, A. B., Becker, J. B., & White, W. L. (2009). Don't wanna go through that madness no more: Quality of life satisfaction as predictor of sustained substance use remission from illicit drug misuse. *Substance Use and Misuse, 44*(2), 227-252. doi:10.1080/10826080802714462

Maguire, M., Sheahan, T. M., & White, W. L. (2011). *"I wanted a new beginning"* Innovations in recovery management for people experiencing prolonged homelessness in the City of Philadelphia. *Alcoholism Treatment Quarterly*, *30*, 3-21.

Marlatt, G.A., Blume, A.W. & Parks, G.A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment, *Journal of Psychoactive Drugs*, 33(1), 13-21;

McKay, J. R., Lynch, K. G., Shepard, D. S., Morgenstern, J., Forman, R. F., & Pettinati, H. M. (2005b). Do patient characteristics and initial progress in treatment moderate the effectiveness of telephone-based continuing care for substance use disorders? *Addiction, 100*(2), 216-226. doi:10.1111/j.1360-0443.2005.00972.x

McKay, J. R., Lynch, K. G., Shepard, 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.

McKay, J. R., Lynch, K. G., Shepard, D. S., Ratichek, S., Morrison, R., Koppenhaver, J., & Pettinati, H. M. (2004). The effectiveness of telephone-based continuing care in the clinical management of alcohol and cocaine use disorders: 12-month outcomes. *Journal of Consulting and Clinical Psychology, 72*(6), 967-979. doi:10.1037/0022-006X.72.6.967

McKay, J. R., Van Horn, D., Oslin, D*. W., Ivey, M., Drapkin, M. L., Coviello, D. M.,…Lynch, K. G. (2011). Extended telephone-based continuing care for alcohol dependence: 24-month outcomes and subgroup analyses. Addiction, 106, 1760-1769. doi:10.1111/j.1360-0443.2011.03483.x*

McKnight, J. (1995). *The Careless Society: Community and its Counterfeits*. New York: Basic Books.

McLellan, T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition: The Betty Ford Consensus Panel and consultants. *Journal of Substance Abuse Treatment, 38, 200-201. doi:10.1016*/j.jsat.2009.11.002

McLellan, A.T. (2003). What's the harm in discussing harm reduction: An introduction to a three-paper series. *Journal of Substance Abuse Treatment*, 25, 239-240.

Miller, W., & C' de Baca, J. (2001). *Quantum change: When epiphanies and sudden insights transform ordinary lives*. New York: Guilford Press.

Morgan, O. J. (1996). Recovery-sensitive counseling in the treatment of alcoholism. *Alcoholism Treatment Quarterly*, *13*(4), 63-73. doi:10.1300/J020v13n04_06

Prochaska, J. O., Velicer, W. F., Rossi, J. S. Goldstein, M. G. Marcus, B. H. Rakowski, W.,…Rossi, S. R. (1994). Stages of change and decisional balance for 12 problem behaviors. *Health Psychology*, *13,* 39-46.

Rieckmann, T., Daley, M., Fuller, B., Thomas, C., & McCarty, D. (2007). Client and counselor attitudes toward the use of medications. *Journal of Substance Abuse Treatment*, *32,* 207– 215.

SAMHSA. (2009). Working definition of recovery. Excerpt from *National*

Summit on Recovery Conference Report, 2005. Rockville, MD: Center for Substance Abuse Treatment. Posted at www.williamwhitepaers.com

SAMHSA. (2011). SAMHSA announces a working definition of "recovery" from mental disorders and substance use disorders. Accessed January 10, 2013 at http://www.samhsa.gov/newsroom/advisories/1112223420.aspx

Timko, C., DeBenedetti, A., & Billow, R. (2006). Intensive referral to 12-step self-help groups and 6-month substance use disorder outcomes. *Addiction, 101*, 678-688. doi:10.1111/j.1360-0443.2006.01391.x

United Kingdom Drug Policy Commission. (2008). *A consensus definition of recovery*. Retrieved June 24, 2010 from http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf.

van Eijk, J., Demirakca, T., Frischknecht, U., Hermann, D., Mann, K., & Ende, G. (2012). Rapid partial regeneration of brain volume during the first 14 days of abstinence from alcohol. *Alcoholism: Clinical & Experimental Research*. Advance online publication. doi:10.1111/j.1530-0277.2012.01853.x

Waldorf, D. (1983). Natural recovery from opiate addiction: Some social-psychological processes of untreated recovery. *Journal of Drug Issues, 13,* 237-280.

Waldorf, D., Reinarman, C., & Murphy, S. (1991). *Cocaine changes: The experience of using and quitting*. Philadelphia, PA: Temple University.

White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. L. (2000). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, *18*(1), 1-23. doi:10.1300/J020v18n01_01

White, W. L. (2000). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly, 18*(2), 1-25. doi:10.1300/J020v18n02_01

White, W. L. (2001). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly, 19*(2), 1-21. doi:10.1300/J020v19n02_01

White, W. L. (2004). Addiction recovery mutual aid groups: An enduring international phenomenon. *Addiction, 99*, 532-538. doi:10.1111/j.1360-0443.2004.00684.x

White, W. L. (2004). Recovery: The next frontier. *Counselor*, *5*(1), 18-21.

White, W. L. (2004). Transformational change: A historical review. *Journal of Clinical Psychology, 60*(5), 461-470. doi:10.1002/jclp.20001

White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 3-15. doi:10.1300/J020v23n01_02

White, W. L. (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.

White, W. L. (2006). Recovery across the life cycle from alcohol/other drug problems: Pathways, styles and developmental stages. *Alcoholism Treatment Quarterly, 24*(1/2), 185-201. doi:10.1300/J020v24n01-11

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241. doi:10.1016/j.jsat.2007.04.015

White, W. L. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703.

doi:10.1111/j.1360-0443.2007.01808.x

White, W. L. (2008a). *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. L. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. (2008c). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment, 36*, 146-158. doi:10.1016/j.jsat.208.10.006

White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. (2010). *Relapse is NOT a part of recovery*. Posted at www.facesandvoicesofrecovery.org and www.williamwhitepapers.com

White, W. L. (2011). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services.

White, W. L. (2012). *Recovery/remission from substance use disorders: An analysis of reported outcomes in 415 scientific studies, 1868-2011*. Chicago: Great Lakes Addiction Technology Transfer Center; Philadelphia Department of Behavioral Health and Developmental disAbilites; Northeast Addiction Technology Transfer Center.

White, W., & Chaney, R. (2012). Commentary--Resilience and recovery across the generations: A critical research agenda. *Counselor*, *13*(2), 54-57.

White, W., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

White, W. L., Evans, A. C., Lamb, R., & Achara-Abrahams, I. (in press). Addiction recovery communities as indigenous cultures: Implications for professional and scientific collaboration. *Alcoholism Treatment Quarterly*.

White, W., Kelly, J., & Roth, J. (2012). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, *7*(2-4), 297-317.

White, W., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches*. Pittsburgh, PA: IRETA/NeATTC.

White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

White, W., Parrino, M., & Ginter, W. (2011). *A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions*. Commissioned briefing paper for SAMHSA's A Dialogue on Psychopharmacology in Behavioral Healthcare meeting, October 11-12, 2011. Posted at www.williamwhitepaers.com

White, W. L., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction

treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395. doi:10.1080/07347320802072198

White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-38.

White, W. & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.

Williams, C., with Laird, R. (1992). *No hiding place: Empowerment and recovery for troubled communities*. New York: Harper San Francisco.

Zweben, J.E. (1986). Recovery oriented psychotherapy. *Journal of Substance Abuse Treatment*, *3*, 255-262. doi:10.1016/0740-5472(86)90037-1



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. (2013). Recovery orientation in addiction counseling: A brief history. *Counselor*, 14(6), 12-16. Posted at **www.williamwhitepapers.com**

Recovery Orientation in Addiction Counseling: A Brief History

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The profession of addiction counseling is historically rooted in the lived experience of recovery, but the degree of recovery orientation in addiction counseling has ebbed and flowed over the course of the e field's history. Four overlapping eras illustrate the evolution in the field's recovery orientation—recovery orientation here defined as respect for recovery-based experiential knowledge, a focus on the facilitation of long-term personal/family recovery, adherence to recovery-linked and scientifically-grounded service practices, and emphasis on the role of community recovery capital in the initiation and maintenance of personal/family recovery.

Recovery Roots of Addiction Counseling

The birth of a specialized helping role to facilitate the resolution of alcohol and other drug problems can be traced to the first persons recovering from such problems who committed their lives to helping others similarly affected. In the United States, such roles included the leaders of 18th and 19th century Native American abstinence-based religious and cultural revitalization movements and the "reformed" temperance missionaries within the Washingtonian Temperance Society (1840s), recovery-focused fraternal temperance societies (1840s-1870s), the Ribbon Reform Clubs (1870s), and such local recovery mutual aid groups as the Drunkards Club in New York City (Coyhis & White, 2006; White, 2000a).

Collectively, these individuals shared their recovery stories in public and private meetings, penned recovery-focused pamphlets and autobiographies, conducted private consultations with individuals and families experiencing addiction-related problems, helped organize local recovery support groups, and maintained prolonged and prolific correspondence with those seeking recovery (White, 1998). The employment of such charismatic recovering figures within the rising network of mid-19th century inebriate homes, inebriate asylums, and private addiction cure institutes marked one of the first controversies and professional splits in the field of addiction treatment. Inebriate homes were often founded and directed by persons in recovery, maintained close links to local recovery mutual aid societies, and emphasized the importance of public commitment (signing the abstinence

pledge), sober fellowship, service to others and the value of short voluntary stays to prime the recovery process. In contrast, inebriate asylums were physician-directed and emphasized physical methods of prolonged, legally mandated institutional treatment emphasizing medical treatments aimed at cure. Inebriate asylum directors attacked the hiring of "reformed men" on the grounds that:

> *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).

The tensions between the inebriate homes, asylums, and institutes; experiential knowledge versus professional knowledge; and recovery support versus medical cure were lost in the larger collapse of addiction treatment and recovery mutual aid groups in the opening decades of the 20th century.

The Addiction Counselor as Paraprofessional Recovery Specialist

The collapse of 19th century addiction treatment in the U.S. left those with the most severe alcohol and other drug problems abandoned to inebriate penal colonies, the back wards of aging state psychiatric asylums, or the "foul cells" of large public hospitals. Those conditions spawned new recovery support efforts, including clinics that trained people in recovery as "lay therapists." Courtenay Baylor, Francis Bishop, and Richard Peabody were among the earliest and most distinguished of such lay therapists and might well be called the first addiction counselors in the United States. This lay therapy tradition was carried forward by Ray McCarthy and others within the Yale alcoholism clinics of the mid-20th century and the extension of Alcoholics Anonymous sponsors into what were first called "AA counselors." IT was further extended with the hiring of "ex-addicts" in the growing network of therapeutic communities, methadone maintenance programs, and outpatient counseling clinics in the 1960s and early 1970s. This emerging "paraprofessional" counselor role incorporated multiple dimensions—the tradition of recovery storytelling (self-disclosure), mutual recovery support, counseling (new skills incorporated from the fields of psychiatry, psychology, and social work), and community recovery resource development and linkage (White, 1998, 1999). The paraprofessional era was marked by high recovery representation within the addiction treatment workforce, close linkages between treatment and local recovery communities (particularly AA), and an emphasis on experiential versus professional/scientific knowledge. The primary and sometimes exclusive credentials the paraprofessional addiction counselor brought to his or her role were personal recovery and a passion to help others recover (White, 1998, 2009b).

Professionalization of Addiction Counseling

The professionalization of addiction counseling unfolded within the emergence of a specialized, revitalized field of addiction treatment—the growth of local treatment programs; formally designated state and federal agencies responsible for planning, funding, and evaluating treatment programs; the extension of insurance coverage for the treatment of alcoholism and other addictions; the rise of hospital-based and private addiction treatment programs; and the emergence of addiction treatment program licensure and accreditation standards. To achieve public and professional credibility, this rebirthed field required an expanded and credentialed addiction counseling workforce.

Two milestones significantly shaped the addiction counselor role. First, addiction treatment migrated toward an acute care intervention (modeling itself on the hospital via early accreditation standards) rather than on the models of more extended recovery support that prevailed during the paraprofessional era. Second, the role of addiction counselor was modeled on clinical functions performed by psychiatrists, psychologists, and social workers. Notably, key functions were lost in this transition, e.g., assertive outreach, community-based recovery resource development, linkage to indigenous recovery supports in the community. The core functions of the addiction counselor narrowed (screen, assess, diagnose, treat/counsel, document, discharge), and substantial state and federal resources were invested in skill development related to these core functions. The professionalization of addiction counseling was also marked by the rise of national and state associations for addiction counselors, the development of certification and licensing standards for addiction professionals (with increased educational requirements), the proliferation of preparatory addictions studies programs in colleges and universities, new resources for continuing education, and improved salaries and benefits for addiction counselors.

The 1970s and 1980s marked the transition of the addiction counselor from the status of paraprofessional to that of a clinical professional on par with other recognized helping roles. Rarely noticed during this period of explosive growth was the decline in recovery representation in the addiction treatment workforce and among executive leadership and governing boards, the erosion of once strong volunteer and alumni programs, weakened connections to local communities of recovery, and a shift in orientation from long-term recovery to ever-briefer periods of treatment. Cyclical episodes of biopsychosocial stabilization became the norm with a growing portion of persons entering treatment with multiple prior admissions. There was throughout the 1990s a sense of great pride in how far the field of addiction treatment had come in a few short decades, but there was also underlying unease that things of great value had been lost in the professionalization, industrialization, and commercialization of addiction treatment (White, 2000b).

The recovery advocates of the 1940s-1960s spent much of their lives advocating for the federal legislation that in the early 1970s established the foundation of modern addiction treatment. They did so in the belief that specialized addiction treatment could provide a portal of entry into recovery for people who could not otherwise initiate or sustain recovery. By the mid1990s, there was a growing sense among a new generation of recovery advocates and many longtenured addiction counselors that the multibillion dollar addiction treatment industry had become disconnected from the larger and more enduring process of addiction recovery and from the grassroots communities whose efforts had had birthed the field (Else, 1999; Morgan, 1995; White, 2002, 2004).

Recovery Renewal

Several contextual conditions set the stage for calls to renew long-term recovery as the central mission of addiction treatment and addiction counseling: the growth and diversification of recovery mutual aid organizations, a new recovery advocacy movement that both supported addiction treatment and challenged its diminished recovery orientation, the emergence of new recovery support institutions as adjuncts and alternatives to addiction treatment, a growing body of research findings on the limitations of the acute care model of addiction treatment, the reconceptualization of addiction as a chronic disorder, and increasing calls to shift treatment of the most severe and complex AOD problems toward a model of sustained recovery management (Dennis & Scott, 2007; Kelly & White, 2011; McLellan, Lewis, O'Brien, & Kleber, 2000; White, 2005, 2008a,b,d; White, Kelly, & Roth, in press; White & McLellan, 2008). It was perhaps inevitable in the face of such

changes that the field's organizing center began to slowly shift from its historical focus on addiction pathology and the mechanics of treatment to rising interest in the prevalence, pathways, and processes of long-term personal and family recovery.

Fulfilling the vision of recovery-focused addiction treatment and addiction counseling will require substantial changes in the field's infrastructure (McLellan, Carise, & Kleber, 2003), service practices (White, 2008c), and evaluation methodologies (McLellan, 2002):

- Recovery-oriented addiction treatment/counseling will require authentic and diverse personal/family recovery representation at all levels of decision-making within the addictions field.
- Major efforts at workforce stabilization and recovery-focused education and training of addiction professionals will need to be undertaken to ensure that each individual/family seeking help will have continuity of contact in a primary recovery support relationship over the course of long-term recovery.
- The diverse pathways and styles of long-term addiction recovery will need to be carefully mapped, and addiction professionals will need to be knowledgeable of the growing varieties of recovery experience and recovery cultures.
- Recovery-focused addiction counseling would extend the goal of acute biopsychosocial stabilization to encompass pre-treatment recovery priming (assertive outreach and engagement) and support for post-stabilization transitions to recovery maintenance, enhanced quality of life in long-term recovery, and family-centered interventions to break intergenerational cycles of problem transmission.
- Patients/families seeking addiction treatment would be routinely informed of independently verified, program and modality specific recovery outcomes (remission and survival rates) as well as the frequency of iatrogenic risks (harmful side-effects)—in the same way patients are today informed of such risks in life-invasive medical procedures for the treatment of cancer or heart disease.
- Recovery-focused assessment activities would move beyond assessment of individual addiction pathology as an intake activity to comprehensive (using global assessment instruments), strengths-based (focusing on the evaluation of personal, family, and community recovery capital) and continual assessment activities.
- Individuals and families once channeled into pre-packaged "programs" would have access to an ever-expanding menu of recovery-focused, science-grounded services/supports—including a broad spectrum of primary and behavioral health care services—that would be personally matched, combined, sequenced, and adequately dosed to maximize their effects on successful recovery initiation and long-term maintenance.
- Multi-disciplinary, multi-agency service models with inclusion of culturally indigenous institutions and healers would become the norm for treating the most severe substance use disorders.
- The service relationship would shift from an expert model toward a partnership model of long-term recovery support.
- The emphasis on professionally-directed treatment planning would be extended to person-directed recovery planning—both processes guided by personal/family choice (White, 2008e) with interim outcomes carefully monitored and communicated to inform continued treatment and recovery support

decisions (McLellan, McKay, Forman, Cacciola, & Kemp, 2005).

- The locus of service delivery for addiction professionals would be extended far beyond specialty sector addiction treatment programs, with addiction professionals 5 working within a broad spectrum of healthcare, educational, business, military, religious, social service, sports, and media settings. Great emphasis would be placed on reaching and serving people within their natural environments using both face-to-face and technology-facilitated support.
- Aftercare as an afterthought in addiction treatment would give way to an emphasis on sustained post-treatment recovery checkups (for at least 5 years for everyone admitted to addiction treatment regardless of discharge status), stage-appropriate recovery education, assertive linkage to recovery mutual aid groups and other indigenous recovery support institutions, and if and when needed, early re-intervention (Dennis & Scott, 2012).
- The distinctive clinical orientation of addiction counselors would be expanded to cover community assessment and recovery resource development and mobilization (White, 2009a). Some addiction professionals would work in specialized roles aimed at the expansion of family and community recovery capital and building bridges of collaboration between professional addiction treatment organizations and the growing networks of recovery mutual aid organizations and other recovery support institutions.

Efforts to increase the recovery orientation of addiction treatment/counseling are underway across the United States under the conceptual rubrics of recovery management and recovery-oriented systems of care. The success or failure of these efforts will exert a powerful influence on the future of addiction recovery in America and the fate of specialty-sector addiction treatment as a cultural institution.

Acknowledgement: Research for this article was supported by NAADAC under the Recovery to Practice initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA). The opinions expressed here are those of the author and do not necessarily reflect the policies of NAADAC or SAMHSA.

About the Author: William White (bwhite@chestnut.org) is Emeritus Senior Research Consultant at Chestnut Health Systems. His collected papers are available at www.williamwhitepapers.com

References

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

Crothers, T. D. (1897). Reformed men as asylum managers. *Quarterly Journal of Inebriety*, 19, 79.

Dennis, M. L., & Scott, C. K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, 4(1), 45-55.

Dennis, M. L., & Scott, C. K. (2012). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence*, 121, 10-17. doi: 10.1016/j.drugalcdep.2011.07.026

Else, J. D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery*, 6(2), 11-23. doi:10.1300/J048v06n02_02

Kelly, J. F., & White, W. L. (Eds., 2011). *Addiction recovery management: Theory,*

science and practice. New York: Springer Science.

McLellan, A. T. (2002). Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction*, 97, 249-252. doi:10.1046/j.1360-0443.2002.00127.x

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment*, 25, 117-121. doi:10.1016/S0740-5472(03)00156-9

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association*, 284(13), 1689-1695. doi:10.1001/jama.284.13.1689

McLellan, A. T., McKay, J. R., Forman, R., Cacciola, J., & Kemp, J. (2005). Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction*, 100, 447-458. doi:10.1111/j.1360-0443.2005.01012.x

Morgan, O. J. (1995). Extended length sobriety: The missing variable. *Alcoholism Treatment Quarterly*, 12(1), 59-71. doi:10.1300/J020v12n01_05

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. L. (1999). The first addiction counselors. *Counselor*, 17(5), 8-10.

White, W. L. (2000a). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism Treatment Quarterly*, 18(1), 1-23. doi:10.1300/J020v18n01_01

White, W. L. (2000b). The history of recovered people as wounded healers: II. The era of professionalization and specialization. *Alcoholism Treatment Quarterly*, 18(2), 1-25. doi:10.1300/J020v18n02_01

White, W. L. (2002). The treatment renewal movement. Counselor, 3(1), 59-61. White, W. L. (2004). Recovery: The next frontier. *Counselor*, 5(1), 18-21.

White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, 23(1), 3-15. doi:10.1300/J020v23n01_02

White, W. L. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care* (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. L. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse*, 43(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. L. (2008c*). 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. L. (2008d). The culture of recovery in America: Recent developments and their significance. *Counselor*, 9(4), 44-51. 7

White, W. L. (2008e). Toward a philosophy of choice: A new era of addiction treatment. *Counselo*r, 9(1), 38-43.

White, W. L. (2009a). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36, 146-158. doi:10.1016/j.jsat.208.10.006

White, W. (2009b). *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. L., Kelly, J., & Roth, J. (in press). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, 7(2-3).

White, W. L., & McLellan, A. T. (2008). Addiction as a chronic disease: Key messages for clients, families and referral sources. *Counselor*, 9(3), 24-33.



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.L., Malinowski Weingartner, R., Levine, M., Evans, A.C., & Lamb, R. (2013). Recovery Prevalence and Health Profile of People in Recovery: Results of a Southeastern Pennsylvania Survey on the Resolution of Alcohol and Other Drug Problems. Published in abridged form in *Journal of Psychoactive Drugs*, 45(4), 287-296. Posted at www.williamwhitepapers.com

Recovery Prevalence and Health Profile of People in Recovery: Results of a Southeastern Pennsylvania Survey on the Resolution of Alcohol and Other Drug Problems

William L. White, M.A.[1]; Rose Malinowski Weingartner, M.P.H.[2], C.P.H; Marvin Levine, M.S.W.[3]; Arthur C. Evans, Jr., Ph.D.[4]; and Roland Lamb, M.A.[5]

Acknowledgements: The SEPA recovery survey was sponsored by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. The Community Health Data Base and Southeastern Pennsylvania Household Health Survey are supported by The Pew Charitable Trusts, The William Penn Foundation, and a network of nearly 400 philanthropic organizations, government agencies, academic institutions, health systems, and non-profit organizations.

Abstract

The emergence of recovery as an organizing construct for behavioral health public policy and the resulting push to increase the recovery orientation of addiction treatment have sparked renewed questions about the prevalence of substance use disorder (SUD) remission/recovery within the general population. The present study reports findings on recovery-related questions imbedded within a public health survey conducted in Philadelphia and four adjacent counties in Southeastern Pennsylvania. The results reveal an adult recovery prevalence rate (9.4%) comparable to rates found in national surveys, but key measures of physical, emotional, and social health of adults in recovery suggest

[1] Senior Research Consultant, Chestnut Health Systems, Punta Gorda, FL.
[2] Research Associate, Public Health Management Corporation, Philadelphia, PA
[3] Deputy Director, Office of Addiction Services, Department of Behavioral Health and Intellectual disAbility Services, Philadelphia, PA
[4] Commissioner, Department of Behavioral Health and Intellectual disAbility Services, Philadelphia, PA
5. Director, Office of Addiction Services, Department of Behavioral Health and Intellectual disAbility Services, Philadelphia, PA

the need for assertive, sustained, and community-based approaches to recovery management that transcend brief episodes of professional intervention.

Keywords: Remission, recovery, recovery prevalence, recovery survey, recovery profile, recovery management

Introduction

The concept of recovery is emerging as a central organizing paradigm for addiction treatment (El-Guebaly 2012; White 2008a, 2007c, 2005) and the larger arena of behavioral healthcare (Davidson & White 2007; Gagne, White, & Anthony 2007; Ralph & Corrigan 2004; Anthony 2000). In response, there have been multiple efforts to achieve consensus on a definition of recovery from substance use disorders (SAMHSA 2011; Betty Ford Institute Consensus Panel 2007; Laudet 2007; White 2007a) and calls for a recovery-focused research agenda (Laudet 2008). To date, studies of recovery prevalence rates in community samples remain limited (Compton et al. 2007 ; Dawson 1996 ; Dawson et al. 2008, 2005; Kessler et al. 1994; Hasin et al. 2007; Hasin et al. 1997; Hasin & Grant 1995; Robins, Locke, & Regier 1991) and confounded by the question,). What is recovery, and by what criteria is this status achieved or lost?

There are considerable differences between recent consensus definitions of recovery and the definition of recovery used to conduct epidemiological studies, Consensus definitions of recovery have focused on three broad criteria: 1) reduction of AOD problems to subclinical levels either through abstinence or deceleration of the frequency, intensity, and consequences of AOD use; 2) improvements in global health; and 3) pro-social community reintegration (e.g., reduced injury to community, positive community reintegration—citizenship; Betty Ford Consensus Panel 2007; McLellan 2010; SAMHSA 2011; White 2007a). These criteria reinforce the notion of recovery as more than the removal of alcohol and drugs from an otherwise unchanged life. They further reflect findings from early recovery studies that some individuals who achieve sustained abstinence following alcohol or other drug dependence may remain substantially impaired in terms of their physical and emotional health and interpersonal functioning (De Soto, O'Donnel, & De Soto 1989; Pattison et al. 1968; Gerard, Sanger, & Wile 1962).

Reports on recovery prevalence in the United States include the Epidemiologic Catchment Area Study (Robins, Locke, & Regier 1991), the National Comorbidity Survey (Kessler et al. 1994), the National Health Interview (Hasin & Grant 1995), the National Longitudinal Alcohol Epidemiologic Survey (Hasin et al. 2007; Hasin et al. 1997; Dawson 1996), and the National Epidemiologic Survey on Alcohol and Related Conditions (Compton et al. 2007; Dawson et al. 2008, 2005). These studies have defined recovery in terms of remission rates, most frequently defined as adults in the general population who met lifetime criteria for an SUD but did not meet SUD diagnostic criteria in the past year.

Remission rates for alcohol use disorders in these studies ranged between 5.3-12.9% of the adult U.S. population (depending on whether they focused on remission from all alcohol use disorders or only alcohol dependence). One study of adult drug use disorder remission in the U.S. reported a remission rate of 8.3%, and two population studies of remission from all SUDs reported remission rates of 10.8% and 15.5% of the adult population. Applying rates from these studies to the current U.S. adult population,

there are an estimated 21-30 million adults in SUD remission, not including remission from nicotine dependence (For review, see White 2012).

The Partnership at Drugfree.org and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) recently conducted a national survey of 2,526 adults, ages 18 or over, using a variation of remission measurement in the form of the question, "Did you once have a problem with drugs or alcohol, but no longer do?" Ten percent of American adults surveyed answered in the affirmative to that question (Feliz 2012). Based on an estimated 2011 adult population of 242, 322, 633 (US Census Bureau 2012), the Partnership and OASAS survey would generate an estimate of adults in recovery in the U.S. of more than 24 million—a figure comparable to the much more methodologically sophisticated epidemiological studies. While there is growing evidence of a substantial population of people in recovery from SUDs, little is known about the demographic and health profile of such individuals—particularly those in remission who have not participated in addiction treatment or an addiction recovery mutual aid group.

In 2004, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) launched a recovery-focused transformation of the City's behavioral health care system (Achara-Abrahams, Evans, & King 2011; Evans 2007). A process of recovery resource mapping was used to help guide the transformation process. Alcohol and other drug (AOD) problem indicator data and community recovery capital (e.g., addiction treatment services, recovery mutual aid meetings, recovery homes, recovery community centers, etc.) were plotted by city ZIP codes to: 1) strategically allocate recovery support resources where they were most needed within the City, and 2) to use recovery-focused benchmark data, including recovery prevalence data, to evaluate the effectiveness of the systems transformation process as a whole and to evaluate particular neighborhood-focused recovery support initiatives. The present paper summarizes the results of a survey of recovery prevalence in Philadelphia and the surrounding counties that was part of this recovery resource mapping process.

Methodology

Survey Sponsorship. To establish a baseline of recovery prevalence data for Philadelphia and its surrounding counties, DBHIDS collaborated with the Public Health Management Corporation (PHMC) to incorporate recovery-focused items into PHMC's 2010 Southeastern Pennsylvania (SEPA) Household Health Survey. This survey began in 1983 and since 1994, has collected data on the health status and health care experiences of adults and children living in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties every two years. The Survey was administered for PHMC by Abt SRBI, a market research firm based in New York City, between June and October 2010.

Sampling. The 2010 Household Health Survey was conducted through telephone interviews with people 18 years of age and older living in 10,006 households in Southeastern Pennsylvania. All telephone households within Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties were eligible to be selected for the sample, as were cell phone users. The sample was stratified by 54 service areas to ensure sufficient representation within smaller geographic subareas. These 54 areas, which combine clusters of ZIP codes, were developed by PHMC using service area information provided by Community Health Data Base members. Each of the 54

service areas has approximately 30,000 to 75,000 adult residents, based upon 2010 population estimates derived from the 2000 U.S. Census. Projection weights were used to estimate a population count based on the survey sample.

Interview Questions. Three questions were added to the PHMC survey to assess recovery prevalence in the targeted catchment areas. Respondents were asked if they "once had an AOD problem that was no longer a problem in their life" and whether someone within their family or someone they personally knew once had such a problem but had resolved it.

Interview Process. The interviews averaged 22 minutes in length. All interviews were administered by telephone, with most households (9,000 total) contacted on home phones ("landlines") using a computerized Random Digit Dialing (RDD) methodology so that households with unpublished numbers and residents who had recently moved would be included in the sample. In households with more than one eligible adult, the adult who last had a birthday was selected as the adult respondent. When needed, the interviews were conducted in Spanish. When a randomly selected adult respondent was unable to be interviewed because of health impairments or language barriers, the interview was conducted with an adult proxy in the household. Of the 10,006 total interviews conducted, 1,006 were conducted by cell phone. Cell phone respondents received the same survey questionnaire as landline respondents. Dialing was by hand, as TCPA (the Telephone Consumer Protection Act) rules prohibit dialing wireless numbers using automated equipment. The adult who answered the cell phone was the selected respondent, as long as he/she was at least 18 years old and lived in Bucks, Chester, Delaware, Montgomery, or Philadelphia Counties.

Analysis: To present the survey data, dichotomous measures were created for each of the indicators evaluated (See left column of Tables 1-5) and unweighted data (weighted data are presented in discussion of prevalence in the population) were used to run crosstabulations and Odds Ratios.

Results

Recovery Prevalence The adult remission rate in the 2012 PHMC survey was 9.45% (11.4% for Philadelphia and 7.5% in the four surrounding counties). That rate converts to an estimated 269,000 adults self-reporting recovery status in the five-county survey catchment area. The 9.45% self-reported remission rate is comparable to the remission rates reported above in the national epidemiological surveys of AOD problems. In a related question, 16.0% of adults in SEPA reported that there was a person in their household or family who was in recovery from an alcohol or drug problem (16.8% for Philadelphia and 15.5% in the four surrounding counties).

Recovery Profile Adults self-reporting recovery status differ demographically from those not self-reporting recovery status. Adults in recovery when compared to adults not self-identifying as being in recovery are more likely to be male (65.4% compared to 44.6%) and Black (31.4% versus 20.2%) and less likely to be White/Caucasian (62% versus 73.4%). There were no significant differences among Hispanics across self-reported recovery status. Adults in recovery and adults not self-identified as being in recovery share similar age distributions. Close to one third of adults in both groups (37.2% and 29.6%) are under the age of 40. While nearly one in three SEPA adults who are not in recovery (27.3%) are age 60 or older, fewer than one in five SEPA adults in recovery are age 60 or older (18.3%).

Personal Assets and Recovery Status Adults in recovery have fewer personal assets than adults not in recovery (See Table 1).

As Table 1 indicates, SEPA adults in recovery have less education, less housing stability, lower employment, lower household incomes, and greater use of government subsidies than persons not reporting recovery status. Nearly one in five adults in recovery did not graduate from high school, and less than one in five has a college degree. Less than half of SEPA adults in recovery are employed full- or part-time, and adults in recovery are nearly four times as likely to describe themselves as unable to work as are those not in recovery. People in recovery are less likely to own their own home and more likely to report great difficulty in affording housing. Adults in recovery are more likely than those not reporting recovery status to live below the poverty level and to receive SSI, SSDI, or food subsidies.

Table 1: Personal Assets by Recovery Status for SEPA Household Health Survey Respondents (N =10,006)

Asset Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
No High School Diploma	17.2%	6.1%	3.190 (2.607-3.903)
No College Degree	79.7%	57.2%	2.939 (2.464-3.507)
No Full or Part-Time Employment	56.1%	43.6%	1.656 (.971-1.389)
Unemployed and Looking	11.4%	6.0%	2.026 (1.604-2.560)
Unable to Work	22.1%	5.9%	4.504 (3.734-5.432)
Rent Home	43.9%	21.9%	2.788 (2.396-3.243)
Difficulty Affording Housing	60.7%	44.5%	1.920 (1.653-2.230)
Household Income Below 100% of Poverty Level	19.8%	7.8%	2.925 (2.421-3.534)
Household Income Below 150% of Poverty Level	36.7%	15.8%	3.083 (2.644-3.595)
Household Income Below 200% of Poverty Level	45.4%	23.6%	2.696 (2.329-3.122)
Receiving Supplemental Security Income	21.1%	10.1%	2.391 (1.989-2.874)

Receiving Social Security Disability	19.0%	7.7%	2.788 (2.295-3.386)
Receiving Food Stamps or SNAP Benefits	30.2%	9.5%	4.111 (3.481-4.855)

Social Capital and Recovery Status Adults in recovery have less family and social capital than adults not reporting recovery status. Table 2 compares the family and social capital of those who are and are not self-identified as persons in recovery.

Adults in recovery are less likely to be married and more likely to be separated or divorced than adults not self-identified as being in recovery. Adults in recovery are less likely to participate in local community groups and feel social connection with their neighbors. They are also more likely than adults not in recovery to know someone outside their immediate family who is in recovery (52.1% vs. 26.8%), but 47.9% of those adults in recovery did not know another person in recovery. Combined with the finding of generally lower levels of social capital for recovery, this suggests that many SEPA adults are initiating and sustaining recovery without significant general and recovery-specific social support.

Table 2: Family and Social Capital by Recovery Status for SEPA Household Health Survey Respondents (N = 10,006)

Family/Social Capital Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Not Married	67.8%	48.5%	2.2371 (1.919-2.611)
Current Status Divorced or Separated	19.0%	10.5%	2.012(1.666-2.429)
Participate in a Community Group	52.4%	43.9%	1.407 (1.218-1.626)
Neighbors Not Willing to Help	51.8%	61.6%	1.490 (1.287-1.727)
Neighbors can't be Trusted	66.2%	82.0%	2.326 (1.976-2.732)
Don't Feel They Belong in their Neighborhood	83.4%	89.4%	1.678 (1.374-2.049
Know Someone Outside Family in Recovery	52.1%	26.8%	2.973 (2.570-3.440)

Health and Recovery Status A significant portion of adults in recovery from alcohol or other drugs experience continued physical health problems (See Table 3). Nearly one third (35.5%) of adults in recovery describe their health as fair or poor compared with 16.6% of adults not in recovery. SEPA adults in recovery also report higher rates of asthma, diabetes, and high blood pressure as well as higher rates of emergency room visits compared to adults not self-identifying as persons in recovery. Persons in recovery report slightly higher levels of obesity and overweight compared with community members not in recovery.

Table 3: Health Indicators by Recovery Status for SEPA Household Health Survey Respondents (N =10,006)

Health Indicator Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Rating Health as Fair or Poor	35.5%	16.6%	2.778 (2.380-3.236)
Asthma Diagnosis	18.2%	14.4%	1.320 (1.094-1.593)
Diabetes Diagnosis	18.2%	12.2%	1.602 (1.326-1.937)
Physical, Mental, or Emotional Disability	35.9%	13.0%	3.753 (3.208-4.390)
High Blood Pressure	42.5%	35.6%	1.334 (1.153-1.544)
Past Year ER Visit	41.8%	27.3%	1.915 (1.653-2.219)
Overweight or Obese	67.3%	6.8%	1.217 (1.043-1.419)

Access to Healthcare and Recovery Status Adults in recovery from alcohol or other drugs face barriers to healthcare. More adults in recovery (14.2%) report having no regular source of health care (no regular place to go when sick or needing health-related advice) compared with 10.0% of adults not in recovery reporting similar circumstances. Of adults in recovery with a regular source of care, only about two thirds (68.5%) get that care at a doctor's office, with the rest identifying their regular source of care as a community health center, outpatient clinic, emergency department, or other source. In contrast, 87.6% of adults not in recovery identify a doctor's office as their regular source of care.

More than one in five SEPA adults in recovery between the ages of 18 and 64 (22.3%) have no public or private health insurance compared with 10.1% of SEPA adults not in recovery in that same age group. Nearly two thirds of adults in recovery without health insurance (62.7%) have visited an ER rather than a doctor's office for care in the past year because they had nowhere else to go (compared with 49.1% of uninsured adults not in recovery). Adults in recovery with health insurance are more likely to be covered by Medicaid than are insured adults not in recovery (25.7% versus 10.1%). Among adults with health insurance, adults in recovery are more likely than adults not in recovery to have been uninsured at some point in the past year (13.7% as compared with 6.1%).

Recovery Status and Healthcare Screenings Many adults in recovery for alcohol or other drugs forego or delay health care and routine screenings (See Table 4).

As indicated in Table 4, during the past year, adults in recovery were less likely than community members not in recovery to seek health and dental care and to fill needed prescriptions due to their costs. Adults in recovery were less likely to receive a mammogram or prostate exam in the past year, but more likely than other community members to have an HIV test in the past year.

Table 4: Health Care/Screening by Recovery Status for SEPA Household Health Survey Respondents (N =10,006)

Health Care/Screening Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Did not Seek Needed Care in Past Year Due to Cost	20.4%	10.2%	2.254 (1.875-2.709)
Did not Get Needed Prescription Due to Cost	25.2%	14.6%	1.963 (1.658-2.325)
Did not Get Dental Care Due to Cost	37.6%	21.4%	2.210 (1.900-2.571)
Women Getting No Mammogram in Past Year	39.4%	34.4%	1.237(.969-1.579)
Men Getting No Prostate Exam in Past Year	53.9%	39.9%	1.760 (1.387-2.232)
No HIV Testing in Past Year	68.9%	82.2%	.480 (.409-.564)

Recovery Status and Management of Health Risks Many adults in recovery have health-related behaviors that increase their risk of disease (See Table 5). More than four in five adults in recovery (81.5%) have been cigarette smokers compared with 43.7% of adults not in recovery. Nearly half of adults in recovery (49.4%) currently smoke compared to only 17.0% of adults not in recovery. Adult smokers in recovery also smoke more than smokers not in recovery. In Philadelphia, for example, smokers in recovery are more likely than other smokers to smoke a pack or more per day (41.0% compared with 32.4%). More than half (58.5%) of smokers in recovery tried to quit smoking during the past year—most (54.3%) via cold turkey, with only 29.8% using nicotine replacement therapy (Malinowski Weingartner et al., 2011). Nearly three in ten adults in recovery (26.8%) reported in the SEPA survey that somebody smokes inside their home compared with 11.5% of adults not in recovery. The health risks of people in recovery also extend to the arenas of exercise and diet, e.g., not exercising at all (16.5% of adults in recovery versus 11.4% of adults not in recovery), not eating any daily servings of fruit (7.2% versus 2.7%), and eating fast food three or more times per week (10.6% versus 5.7%).

Table 5: Behavioral Risk Factors and Recovery Status for SEPA Household Health Survey Respondents (N = 10,006)

Behavioral Risk Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Lifetime Smoking	81.5%	43.7%	5.689 (4.740-6.829)
Current Smoking	49.4%	17.0%	4.757 (4.101-5.519)
Exposed to Smoke in Home	26.8%	11.5%	2.826 (2.388-3.344)
Report no Regular Exercise	16.5%	11.4%	1.541 (1.266-1.876)
Report no Daily Serving of Fruit	7.2%	2.7%	2.805 (2.077-3.788)
Report Fast Food 3 or More Times per Week	10.6%	5.7%	1.953 (1.536-2.484)

Access to other Health Resources and Recovery Status Many adults in recovery have limited access to the resources they need in order to make healthy choices. Nearly one in five (19.9%) adults in recovery reported that the quality of groceries in their neighborhood is fair or poor compared to 11.9% of adults not in recovery. One third of adults in recovery (33.1%) have to travel outside their neighborhood to go to a supermarket compared with 28% of adults not in recovery.

Emotional Health and Recovery Status Many adults in recovery are affected by psychological and emotional difficulties. More than one in three adults in recovery (38%) have been diagnosed with a mental health condition compared to only 12.3% of adults not in recovery. Nearly two thirds of adults in recovery who have a mental health condition (66.2%) receive treatment for that mental health condition—greater than the 60.2% of adults not in recovery that receive treatment for a diagnosed mental health condition(s). More than one in five adults in recovery (21%) report experiencing an extreme amount of stress compared to only 9.1% of adults not in recovery.

Discussion

Limitations. Past epidemiological studies that have attempted to measure the prevalence of recovery in the general population have relied on the measure of remission—the prevalence of persons reporting meeting lifetime SUD diagnostic criteria but not past year SUD diagnostic criteria (Compton et al. 2007; Dawson 1996; Dawson et al. 2008, 2005; Kessler et al. 1994; Hasin et al. 2007; Hasin et al. 1997; Hasin & Grant 1995; Robins, Locke, & Regier 1991). Such study designs are expensive and difficult to replicate for cities and counties wishing to use recovery prevalence data for planning and evaluation purposes. DBHIDS and PHMC added a small number of questions to an existing public health survey instrument, and defined recovery as an affirmative response to the question: "Did you once have an alcohol or other drug problem that is no longer a problem in your life?"—a question similar to that recently used in the Partnernship OASAS recovery prevalence study (Feliz 2012). Without SUD

diagnostic criteria or other measures of problem severity embedded within the survey questions, it is quite possible that aggregate affirmative responses to this question inflate the estimate of adults "in recovery" by including persons with transient subclinical, AOD-related problems. Responses to questions about recovery status may be affected by social desirability bias, resulting in an under-reporting of recovery status. Aggregate negative responses to the question could also be deflated by the inclusion of persons in recovery who, though in remission and/or abstinent, continue to see themselves as having an alcohol or other drug problem that needs active management on par with other chronic disorders such as asthma, diabetes or heart disease. Defining recovery using a single factor (remission/ problem resolution) also belies the increased understanding of recovery as a multidimensional state.

The category of persons not reporting recovery status in the SEPA survey is also ambiguous in that it includes people who have never used alcohol or drugs, people who have used alcohol or drugs without self-perceived problems, people who have present and continuing AOD problems, and people who once had but no longer have AOD problems but choose not to self-identify that status. These categorical ambiguities limit study conclusions.

Recovery Prevalence. Three questions related to recovery from alcohol and other drug problems were added to the 2010 Southeastern Pennsylvania (SEPA) health survey. Of the more than 10,000 individuals interviewed, 9.45% of survey respondents reported having had an alcohol or drug problem that was no longer a problem in his or her life. This compares to rates of SUD remission reported in national epidemiological studies (10.8%; Kessler, et al. 2005a,b), combined rates for separate studies of alcohol and drug use disorder remission rates (5.3%; Dawson et al. 2008; 8.3%; Compton et al. 2007), and the rate from a just-released national telephone survey of recovery prevalence whose wording of the key recovery status question was close to that used in the SEPA survey (10%; Feliz 2012). Caution is warranted in thinking of the categories of "in recovery" and "not in recovery" as fixed states. Studies of clinical populations show a high degree of movement between these states in the three years following addiction treatment (Scott, Foss, & Dennis 2005), and studies of "natural recovery" (recovery without aid of professional treatment) in community populations also reveal such early instability (Moos & Moos 2005). Measuring time in recovery in future cross-sectional surveys of recovery prevalence would add a dimension that could have great import to planning local recovery support services across the stages of recovery.

What is clear from the present study and the national epidemiological studies of recovery is that there is a large population of people in recovery who could be potentially mobilized to promote recovery-focused social policies and expand local recovery support services (White 2009a)—a process that is already underway in many U.S. communities (White 2007b).

Demography of Recovery. The demographic profile of those in recovery in SEPA is similar to that reported in a recent national survey of adults in recovery (Feliz 2012). People in recovery are more likely to be male than female and more likely to be middle aged than a young or older adult. The dominance of middle-age recovery prevalence is congruent with the concept of addiction/treatment careers and the progressive acceleration of AOD use and related consequences that often precede recovery initiation (Anglin et al. 2001). The lower recovery representation among older adults may represent generational patterns of AOD problem development, age-related rates of recovery initiation, and age-related differences in comfort in self-reporting recovery

status. It could also reflect attrition in recovery prevalence in the transition from middle adulthood to older adulthood via erosion of recovery stability during late life transitions or a higher mortality rate of people in recovery (Scott et al. 2011; Gossop et al. 2002; Hser et al. 2001; Zanis & Woody 1998; Edwards 1989). Comparing demographic data related to AOD problems with the demographic profile of people in recovery could help policy makers target recovery support resources to locations and populations in greatest need of services.

Family and Social Recovery Capital. The SEPA study revealed that adults in recovery are less connected to family, neighborhood, and community life than adults not in recovery. This could reflect the damage done to family, social, and community relationships as a consequence of excessive and prolonged AOD use and the effects of social stigma on community re-integration during recovery. This would suggest the value of community-based recovery support services specifically focused on repair of relationships with family and kinship networks and guidance through the transitions from cultures of drug use to cultures of recovery to recovery-supportive relationships within the larger community (White 2009b).

A striking finding was that 47.2% of SEPA adults in recovery reported not knowing another person in recovery outside their family. Studies of recovery in treated populations have underscored the role of general social support and recovery-specific support in enhancing long-term outcomes (Groh et al. 2007; Laudet, Morgen, & White 2006; McCrady 2004; Broome, Simpson, & Joe 2002; Beattie & Longabaugh 1999; Humphreys, Moos, & Cohen 1997). The SEPA study suggests that many people are sustaining SUD recovery without participation in the peer-based mutual support available in most treatment settings and in all recovery support groups.

Recovery Health Profile. While mortality rates among persons treated for SUDs decline and many areas of personal and social functioning improve with sustained abstinence (Hibbert & Best 2011; Scott et al. 2011), it is clear that many people entering recovery bring burdens of impaired physical and emotional health and social isolation that can compromise their future quality of life as well as their life expectancies. SEPA adults in recovery, compared to those not identifying recovery status, report greater health-related problems, greater barriers in seeking health care, greater risk behaviors associated with chronic health problems, and less social capital to manage the effects of such problems.

The prevailing acute care model of addiction treatment rests on the assumption that the transition from recovery initiation to stable recovery maintenance and concomitant improvements in global health and social functioning will continue following addiction treatment without continued professional monitoring and support. High rates of post-treatment resumption of AOD use (more than 50% as reviewed by White 2008b) following addiction treatment and the quality of life data from the present survey challenge this assumption. There have been growing calls to extend addiction treatment from an acute care model of intervention to models of sustained recovery management, particularly for those persons with the most severe, complex, and chronic SUDs (Dennis & Scott 2007; McLellan, Lewis, O'Brien, & Kleber 2000; White 2008b). The primary purpose of such advocacy has been to ensure post-treatment recovery stabilization and maintenance. The present survey results suggest a different agenda: reducing addiction-related burdens brought into the recovery process and enhancing quality of life and health in long-term recovery for treated and untreated populations in recovery. The increased integration of primary health care, mental health care, and

addiction treatment inherent in current health care reforms may offer increased opportunities for achieving these multiple goals (Mechanic 2012; Buck 2011).

The role smoking (nicotine addiction) plays in increased morbidity and mortality of people in recovery from other SUDs deserves intensified attention in the addictions field. The SEPA survey reveals a high rate of smoking among people in recovery, chronic health conditions associated with smoking, and a desire and efforts by people in recovery to quit smoking. Other studies of people with past or present SUDs confirm high rates of smoking, heavy smoking, smoking-related diseases, and smoking-related mortality (Hurt, et al. 1996; Hser, McCarthy, & Anglin 1994). These findings in tandem with evidence that smoking cessation improves recovery outcomes for other drug dependencies (Kalman et al. 2010; Prochaska, Delucchi, & Hall 2004; Kohn, Tsoh, & Weisner 2003) have triggered efforts to integrate smoking cessation into addiction treatment (Knudsen et al. 2010). The SEPA study confirms the need for such efforts and for similar community-based efforts to support smoking cessation among people in recovery who are not involved in addiction treatment.

*Recovery Status and Barriers to Health Care. A*dults in recovery reported less access and utilization of health care resources than adults not reporting recovery status. The reduced access to regular health care and prescription medications reported by people in recovery is likely linked to lower income levels and lower levels of public and private health insurance coverage. Combined with reports of behavioral risks related to smoking and inadequate diet and exercise, these findings suggest that models of sustained recovery management integrate on-site primary health care or assertive linkage to primary health care within their service protocols.

Future Research. Regular replications of recovery surveys could examine recovery prevalence changes over time by key demographic variables, the influence of professional treatment, recovery mutual aid, or alternative recovery support mechanisms, and the prevalence of particular recovery pathways and styles of recovery. *Conclusions.* Questions related to the resolution of AOD problems can be added to existing community surveys to provide valuable information for service system planning and evaluation. This five-county Southeastern Pennsylvania population survey of recovery from AOD problems adds to the body of studies documenting a significant population of adults (approximately 10% of the adult population) who have experienced and subsequently resolved an AOD problem. The finding that people in recovery experience greater health problems, greater obstacles to health care, and greater behavioral risks predictive of compromised health and life expectancies than other community members calls for integrating primary health care into strategies of long-term recovery management for both treated and untreated populations seeking to resolve AOD-related problems. This study confirms the value of conceptualizing addiction as a chronic disorder not just in terms of the often long course of active drug use and the frequent cycles of remission and reoccurrence, but also for the physical, emotional, and social legacies that extend far into the long-term personal and family recovery processes.

Problems of physical health and problems of compromised personal assets (specifically in the arenas of education, employment, income, housing, and health insurance), family alienation, and social marginalization do not spontaneously remit on the heels of recovery initiation. Existing models of professional and peer interventions may open the doorway to recovery, but new models are needed to help people achieve and sustain global health and positive community reintegration in long-term recovery.

References

Achara-Abrahams, I.; Evans, A.C. & King, J.K. 2011. Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In: J.F. Kelly & W.L. White (Eds.) *Addiction Recovery Management: Theory, Science and Practice*. New York: Springer Science.

Anglin, M.D.; Hser, Y.; Grella, C.; Longshore, D. & Prendergast, M. 2001. Drug treatment careers: Conceptual overview and clinical research, and policy applications. In: F. Tims; C. Leukefeld & J. Platt (Eds.) *Relapse and Recovery in Addictions*. New Haven: Yale University Press.

Anthony, W.A. 2000. A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal* 24 (2): 159-168.

Beattie, M.C. & Longabaugh, R. 1999. General and alcohol-specific social support following treatment. *Addictive Behaviors* 24 (5): 593-606.

The Betty Ford Institute Consensus Panel. 2007. What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment* 33 (3): 221-228.

Broome, K.M.; Simpson, D.D. & Joe, G.W. 2002. The role of social support following short-term inpatient treatment. *American Journal on Addictions* 11 (1): 57-65.

Buck, J.A. 2011. The looming expansion and transformation of public substance abuse treatment under The Affordable Care Act. *Health Affairs* 30 (8): 1402-1410.

Compton, W.M.; Thomas, Y.F.; Stinson, F.S. & Grant, B.F. 2007. Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry* 64 (5): 566-576.

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* 34 (2): 109-120.

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.

Dawson, D.A.; Grant, B.F.; Stinson, F.S.; Chou, P.S.; Huang, B. & Ruan, W.J. 2005. Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction* 100 (3): 281-292.

Dawson, D.A.; Stinson, F.S.; Chou, S.P. & Grant, B.F. 2008. Three-year changes in adult risk drinking behavior in relation to the course of alcohol-use disorders. *Journal of Studies on Alcohol and Drugs* 69 (6): 866-877.

De Soto, C.B.; O'Donnell, W.E. & De Soto, J.L. 1989. Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research* 13 (5): 693-697.

Dennis, M. & Scott, C.K. 2007. Managing addiction as a chronic condition. *Addiction Science & Clinical Practice* 4 (1): 45-55.

Edwards, G. 1989. As the years go rolling by: Drinking problems in the time dimension. *British Journal of Psychiatry* 154 (1): 18-26.

El-Guebaly, N. 2012. The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine* 6 (1): 1-9.

Evans, A.C. 2007. The recovery-focused transformation of an urban behavioral health care system: An interview with Arthur Evans, PhD. In: W.L. White (Ed.)

Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-oriented System of Care. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Feliz, J. 2012. *Survey: Ten Percent of American Adults Report Being in Recovery from Substance Abuse or Addiction. The Partnership at Drugfree.org and The New York State Office of Alcoholism and Substance Abuse Services*. Retrieved July 17 from: http://www.drugfree.org/newsroom/survey-ten-percent-of-american-adults-report-being-in-recovery-from-substance-abuse-or-addiction

Gagne, C.; 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.

Gerard, D.L.; Sanger, G. & Wile, R. 1962. The abstinent alcoholic. *Archives of General Psychiatry* 6 (1): 83-95.

Gossop, M.; Stewart, D.; Treacy, S. & Marsden, J. 2002. A prospective study of mortality among drug misusers during a 4-year period after seeking treatment. *Addiction* 97 (1): 39-47.

Groh, D.R.; Jason, L.A.; Davis, M.I.; Olson, B.D. & Ferrari, J.R. 2007. Friends, family, and alcohol abuse: An examination of general and alcohol-specific social support. *The American Journal on Addictions* 16 (1): 49-55.

Hasin, D.S. & Grant, B.F. 1995. AA and other helpseeking for alcohol problems: Former drinkers in the U.S. general population. *Journal of Substance Abuse* 7 (3): 281-292.

Hasin, D.S.; Stinson, F.S.; Ogburn, E. & Grant, B.F. 2007. Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry* 64 (7): 830-842.

Hasin, D.S.; Van Rossem, R.; McCloud, S. & Endicott, J. 1997. Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. *Journal of Substance Abuse* 9: 127-135.

Hibbert, L.J. & Best, D.W. 2011. Assessing recovery and functioning in former problem drinkers at different stages of their recovery journeys. *Drug and Alcohol Review* 30 (1): 12-20.

Hser, Y-I.; Hoffman, V.; Grella, C.E. & Anglin, M.D. 2001. A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry* 58 (5): 503-508.

Hser, Y.I.; McCarthy, W.J. & Anglin, M.D. 1994. Tobacco use as a distal predictor of mortality among long-term narcotics addicts. *Preventive Medicine* 23 (1): 61-69.

Humphreys, K.; Moos, R.H. & Cohen, C. 1997. Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol* 58 (3): 231-238.

Hurt, R.D.; Offord, K.P.; Croghan, I.T.; Gomez-Dahl, L.; Kottke, T.E.; Morse, R.M. & Melton, J., III. 1996. Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. *Journal of the American Medical Association* 274 (14): 1097-1103.

Kalman, D.; Kim, S.; DiGirolamo, G.; Smelson, D. & Ziedonis, D. 2010. Addressing tobacco use disorder in smokers in early remission from alcohol dependence: The case for integrating smoking cessation services in substance use disorder treatment programs. *Clinical Psychology Review* 30 (1): 12-24.

Kessler, R.C.; Berglund, P.; Demler, O.; Jin, R.; Merikangas, K.R. & Walters, E.E. 2005a. Lifetime prevalance and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* 62 (6): 593-603.

Kessler, R.C.; Chiu, W.T.; Demier, O. & Walters, E.E. 2005b. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorobity Survey replication. *Archives of General Psychiatry* 62 (6): 617-627.

Kessler, R.C.; McGonagle, K.A.; Zhao, S.; Nelson, C.B.; Hughes, M.; Eshelman, S.; Wittchen, H.U. & Kendler, K.S. 1994. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry* 51 (1): 8-19.

Knudsen, H.K.; Studts, J.L.; Boyd, S. & Roman, P.M. 2010. Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. *Journal of the Addictive Diseases* 29 (3): 294-305.

Kohn, C.S.; Tsoh, J.Y. & Weisner, C.M. 2003. Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. *Drug and Alcohol Dependence* 69 (1): 61-71.

Laudet, A.B. 2008. The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Substance Use & Misuse* 43 (12-13): 2001-2020.

Laudet, A.B. 2007. What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment* 33 (3): 243-256.

Laudet, A.B.; Morgen, K. & White, W.L. 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 problems. *Alcoholism Treatment Quarterly* 24 (1-2): 33-73.

McCrady, B.S. 2004. To have but one true friend: Implications for practice of research on alcohol use disorders and social network. *Psychology of Addictive Behaviors* 18 (2): 113-121.

McLellan, A.T.; Lewis, D.C.; O'Brien, C.P. & Kleber, H.D. 2000. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association* 284 (13): 1689-1695.

McLellan, T. 2010. What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment* 38 (2): 200-201.

Mechanic, D. 2012. Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Affairs* 31 (2): 376-382.

Moos, R.H. & Moos, B.S. 2005. Sixteen-year changes and stable remission among treated and untreated individuals with alcohol use disorders. *Drug and Alcohol Dependence* 80 (3): 337-347.

Pattison, E.M.; Headley, E.B.; Gleser, G.C. & Gottschalk, L.A. 1968. Abstinence and normal drinking: An assessment of change in drinking patterns in alcoholics after treatment. *Quarterly Journal of Studies on Alcohol* 29 (3): 610-633.

Prochaska, J.J.; Delucchi, K. & Hall, S.M. 2004. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology* 72 (6): 1144-1156.

Ralph, R. & Corrigan, P. (Eds.) 2004. *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington DC: American Psychological Association.

Robins, L.N.; Locke, B.Z. & Regier, D. 1991. An overview of psychiatric disorders in America. In: L.N. Robins & D.A. Regier (Eds.) *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. New York: The Free Press.

SAMHSA. 2011. *SAMHSA's Working Definition of Recovery Updated*. Retrieved July 20, 2012 from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

Scott, C.K.; Dennis, M.L.; Laudet, A.; Funk, R.R. & Simeone, R.S. 2011. Surviving drug addiction: The effect of treatment and abstinence on mortality. *American Journal of Public Health* 101 (4): 737-744.

Scott, C.K.; Foss, M.A. & Dennis, M.L. 2005. Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment* 28 (Supplement 1): S63-S72.

U.S. Census Bureau (2012) USA Quick Facts from the US Census Bureau: Department of Commerce. Accessed October 16 at http://quickfacts.census.gov/qfd/states/00000.html

Weingartner, R.M.; Minot, K.O.; Coughey, K.; Gutierrez, M. & Kotranski, L. 2011. *Smoking Cessation Among Persons with Behavioral Health Issues*. Presented at the American Public Health Association Meeting, Washington D.C., October 31, 2012. Retrieved July 18, 2012 from https://apha.confex.com/apha/139am/webprogram/Paper244419.html

White, W.L. 2012. *Recovery/remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Studies, 1868-2011*. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual disAbility Services Mental Retardation Services and Northeast Addiction Technology Transfer Center.

White, W.L. 2009a. The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment* 36 (2): 146-158.

White, W.L. 2009b. *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W.L. 2008a. Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse* 43 (12&13): 1987-2000.

White, W.L. 2008b. *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.L. 2007a. Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment* 33 (3): 229-241.

White, W.L. 2007b. The new recovery advocacy movement in America. *Addiction* 102 (5): 696-703.

White, W.L. 2007c. *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-oriented System of Care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W.L. 2005. Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly* 23 (1): 3-15.
Zanis, D.A. & Woody, G.E. 1998. One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence* 52 (3): 257-260.



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.L., Malinowski Weingartner, R., Levine, M., Evans, A.C., & Lamb, R. (2013). Recovery Prevalence and Health Profile of People in Recovery: Results of a Southeastern Pennsylvania Survey on the Resolution of Alcohol and Other Drug Problems. Published in abridged form in *Journal of Psychoactive Drugs*, 45(4), 287-296. Posted at www.williamwhitepapers.com

Recovery Prevalence and Health Profile of People in Recovery: Results of a Southeastern Pennsylvania Survey on the Resolution of Alcohol and Other Drug Problems

William L. White, M.A.[1]; Rose Malinowski Weingartner, M.P.H.[2], C.P.H; Marvin Levine, M.S.W.[3]; Arthur C. Evans, Jr., Ph.D.[4]; and Roland Lamb, M.A.[5]

Acknowledgements: The SEPA recovery survey was sponsored by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. The Community Health Data Base and Southeastern Pennsylvania Household Health Survey are supported by The Pew Charitable Trusts, The William Penn Foundation, and a network of nearly 400 philanthropic organizations, government agencies, academic institutions, health systems, and non-profit organizations.

Abstract

The emergence of recovery as an organizing construct for behavioral health public policy and the resulting push to increase the recovery orientation of addiction treatment have sparked renewed questions about the prevalence of substance use disorder (SUD) remission/recovery within the general population. The present study reports findings on recovery-related questions imbedded within a public health survey conducted in Philadelphia and four adjacent counties in Southeastern Pennsylvania. The results reveal an adult recovery prevalence rate (9.4%) comparable to rates found in national surveys, but key measures of physical, emotional, and social health of adults in recovery suggest

[1] Senior Research Consultant, Chestnut Health Systems, Punta Gorda, FL.
[2] Research Associate, Public Health Management Corporation, Philadelphia, PA
[3] Deputy Director, Office of Addiction Services, Department of Behavioral Health and Intellectual disAbility Services, Philadelphia, PA
[4] Commissioner, Department of Behavioral Health and Intellectual disAbility Services, Philadelphia, PA
5. Director, Office of Addiction Services, Department of Behavioral Health and Intellectual disAbility Services, Philadelphia, PA

the need for assertive, sustained, and community-based approaches to recovery management that transcend brief episodes of professional intervention.

Keywords: Remission, recovery, recovery prevalence, recovery survey, recovery profile, recovery management

Introduction

The concept of recovery is emerging as a central organizing paradigm for addiction treatment (El-Guebaly 2012; White 2008a, 2007c, 2005) and the larger arena of behavioral healthcare (Davidson & White 2007; Gagne, White, & Anthony 2007; Ralph & Corrigan 2004; Anthony 2000). In response, there have been multiple efforts to achieve consensus on a definition of recovery from substance use disorders (SAMHSA 2011; Betty Ford Institute Consensus Panel 2007; Laudet 2007; White 2007a) and calls for a recovery-focused research agenda (Laudet 2008). To date, studies of recovery prevalence rates in community samples remain limited (Compton et al. 2007 ; Dawson 1996 ; Dawson et al. 2008, 2005; Kessler et al. 1994; Hasin et al. 2007; Hasin et al. 1997; Hasin & Grant 1995; Robins, Locke, & Regier 1991) and confounded by the question,). What is recovery, and by what criteria is this status achieved or lost?

There are considerable differences between recent consensus definitions of recovery and the definition of recovery used to conduct epidemiological studies, Consensus definitions of recovery have focused on three broad criteria: 1) reduction of AOD problems to subclinical levels either through abstinence or deceleration of the frequency, intensity, and consequences of AOD use; 2) improvements in global health; and 3) pro-social community reintegration (e.g., reduced injury to community, positive community reintegration—citizenship; Betty Ford Consensus Panel 2007; McLellan 2010; SAMHSA 2011; White 2007a). These criteria reinforce the notion of recovery as more than the removal of alcohol and drugs from an otherwise unchanged life. They further reflect findings from early recovery studies that some individuals who achieve sustained abstinence following alcohol or other drug dependence may remain substantially impaired in terms of their physical and emotional health and interpersonal functioning (De Soto, O'Donnel, & De Soto 1989; Pattison et al. 1968; Gerard, Sanger, & Wile 1962).

Reports on recovery prevalence in the United States include the Epidemiologic Catchment Area Study (Robins, Locke, & Regier 1991), the National Comorbidity Survey (Kessler et al. 1994), the National Health Interview (Hasin & Grant 1995), the National Longitudinal Alcohol Epidemiologic Survey (Hasin et al. 2007; Hasin et al. 1997; Dawson 1996), and the National Epidemiologic Survey on Alcohol and Related Conditions (Compton et al. 2007; Dawson et al. 2008, 2005). These studies have defined recovery in terms of remission rates, most frequently defined as adults in the general population who met lifetime criteria for an SUD but did not meet SUD diagnostic criteria in the past year.

Remission rates for alcohol use disorders in these studies ranged between 5.3-12.9% of the adult U.S. population (depending on whether they focused on remission from all alcohol use disorders or only alcohol dependence). One study of adult drug use disorder remission in the U.S. reported a remission rate of 8.3%, and two population studies of remission from all SUDs reported remission rates of 10.8% and 15.5% of the adult population. Applying rates from these studies to the current U.S. adult population,

there are an estimated 21-30 million adults in SUD remission, not including remission from nicotine dependence (For review, see White 2012).

The Partnership at Drugfree.org and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) recently conducted a national survey of 2,526 adults, ages 18 or over, using a variation of remission measurement in the form of the question, "Did you once have a problem with drugs or alcohol, but no longer do?" Ten percent of American adults surveyed answered in the affirmative to that question (Feliz 2012). Based on an estimated 2011 adult population of 242, 322, 633 (US Census Bureau 2012), the Partnership and OASAS survey would generate an estimate of adults in recovery in the U.S. of more than 24 million—a figure comparable to the much more methodologically sophisticated epidemiological studies. While there is growing evidence of a substantial population of people in recovery from SUDs, little is known about the demographic and health profile of such individuals—particularly those in remission who have not participated in addiction treatment or an addiction recovery mutual aid group.

In 2004, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) launched a recovery-focused transformation of the City's behavioral health care system (Achara-Abrahams, Evans, & King 2011; Evans 2007). A process of recovery resource mapping was used to help guide the transformation process. Alcohol and other drug (AOD) problem indicator data and community recovery capital (e.g., addiction treatment services, recovery mutual aid meetings, recovery homes, recovery community centers, etc.) were plotted by city ZIP codes to: 1) strategically allocate recovery support resources where they were most needed within the City, and 2) to use recovery-focused benchmark data, including recovery prevalence data, to evaluate the effectiveness of the systems transformation process as a whole and to evaluate particular neighborhood-focused recovery support initiatives. The present paper summarizes the results of a survey of recovery prevalence in Philadelphia and the surrounding counties that was part of this recovery resource mapping process.

Methodology

Survey Sponsorship. To establish a baseline of recovery prevalence data for Philadelphia and its surrounding counties, DBHIDS collaborated with the Public Health Management Corporation (PHMC) to incorporate recovery-focused items into PHMC's 2010 Southeastern Pennsylvania (SEPA) Household Health Survey. This survey began in 1983 and since 1994, has collected data on the health status and health care experiences of adults and children living in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties every two years. The Survey was administered for PHMC by Abt SRBI, a market research firm based in New York City, between June and October 2010.

Sampling. The 2010 Household Health Survey was conducted through telephone interviews with people 18 years of age and older living in 10,006 households in Southeastern Pennsylvania. All telephone households within Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties were eligible to be selected for the sample, as were cell phone users. The sample was stratified by 54 service areas to ensure sufficient representation within smaller geographic subareas. These 54 areas, which combine clusters of ZIP codes, were developed by PHMC using service area information provided by Community Health Data Base members. Each of the 54

service areas has approximately 30,000 to 75,000 adult residents, based upon 2010 population estimates derived from the 2000 U.S. Census. Projection weights were used to estimate a population count based on the survey sample.

Interview Questions. Three questions were added to the PHMC survey to assess recovery prevalence in the targeted catchment areas. Respondents were asked if they "once had an AOD problem that was no longer a problem in their life" and whether someone within their family or someone they personally knew once had such a problem but had resolved it.

Interview Process. The interviews averaged 22 minutes in length. All interviews were administered by telephone, with most households (9,000 total) contacted on home phones ("landlines") using a computerized Random Digit Dialing (RDD) methodology so that households with unpublished numbers and residents who had recently moved would be included in the sample. In households with more than one eligible adult, the adult who last had a birthday was selected as the adult respondent. When needed, the interviews were conducted in Spanish. When a randomly selected adult respondent was unable to be interviewed because of health impairments or language barriers, the interview was conducted with an adult proxy in the household. Of the 10,006 total interviews conducted, 1,006 were conducted by cell phone. Cell phone respondents received the same survey questionnaire as landline respondents. Dialing was by hand, as TCPA (the Telephone Consumer Protection Act) rules prohibit dialing wireless numbers using automated equipment. The adult who answered the cell phone was the selected respondent, as long as he/she was at least 18 years old and lived in Bucks, Chester, Delaware, Montgomery, or Philadelphia Counties.

Analysis: To present the survey data, dichotomous measures were created for each of the indicators evaluated (See left column of Tables 1-5) and unweighted data (weighted data are presented in discussion of prevalence in the population) were used to run crosstabulations and Odds Ratios.

Results

Recovery Prevalence The adult remission rate in the 2012 PHMC survey was 9.45% (11.4% for Philadelphia and 7.5% in the four surrounding counties). That rate converts to an estimated 269,000 adults self-reporting recovery status in the five-county survey catchment area. The 9.45% self-reported remission rate is comparable to the remission rates reported above in the national epidemiological surveys of AOD problems. In a related question, 16.0% of adults in SEPA reported that there was a person in their household or family who was in recovery from an alcohol or drug problem (16.8% for Philadelphia and 15.5% in the four surrounding counties).

Recovery Profile Adults self-reporting recovery status differ demographically from those not self-reporting recovery status. Adults in recovery when compared to adults not self-identifying as being in recovery are more likely to be male (65.4% compared to 44.6%) and Black (31.4% versus 20.2%) and less likely to be White/Caucasian (62% versus 73.4%). There were no significant differences among Hispanics across self-reported recovery status. Adults in recovery and adults not self-identified as being in recovery share similar age distributions. Close to one third of adults in both groups (37.2% and 29.6%) are under the age of 40. While nearly one in three SEPA adults who are not in recovery (27.3%) are age 60 or older, fewer than one in five SEPA adults in recovery are age 60 or older (18.3%).

Personal Assets and Recovery Status Adults in recovery have fewer personal assets than adults not in recovery (See Table 1).

As Table 1 indicates, SEPA adults in recovery have less education, less housing stability, lower employment, lower household incomes, and greater use of government subsidies than persons not reporting recovery status. Nearly one in five adults in recovery did not graduate from high school, and less than one in five has a college degree. Less than half of SEPA adults in recovery are employed full- or part-time, and adults in recovery are nearly four times as likely to describe themselves as unable to work as are those not in recovery. People in recovery are less likely to own their own home and more likely to report great difficulty in affording housing. Adults in recovery are more likely than those not reporting recovery status to live below the poverty level and to receive SSI, SSDI, or food subsidies.

Table 1: Personal Assets by Recovery Status for SEPA Household Health Survey Respondents (N =10,006)

Asset Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
No High School Diploma	17.2%	6.1%	3.190 (2.607-3.903)
No College Degree	79.7%	57.2%	2.939 (2.464-3.507)
No Full or Part-Time Employment	56.1%	43.6%	1.656 (.971-1.389)
Unemployed and Looking	11.4%	6.0%	2.026 (1.604-2.560)
Unable to Work	22.1%	5.9%	4.504 (3.734-5.432)
Rent Home	43.9%	21.9%	2.788 (2.396-3.243)
Difficulty Affording Housing	60.7%	44.5%	1.920 (1.653-2.230)
Household Income Below 100% of Poverty Level	19.8%	7.8%	2.925 (2.421-3.534)
Household Income Below 150% of Poverty Level	36.7%	15.8%	3.083 (2.644-3.595)
Household Income Below 200% of Poverty Level	45.4%	23.6%	2.696 (2.329-3.122)
Receiving Supplemental Security Income	21.1%	10.1%	2.391 (1.989-2.874)

Receiving Social Security Disability	19.0%	7.7%	2.788 (2.295-3.386)
Receiving Food Stamps or SNAP Benefits	30.2%	9.5%	4.111 (3.481-4.855)

Social Capital and Recovery Status Adults in recovery have less family and social capital than adults not reporting recovery status. Table 2 compares the family and social capital of those who are and are not self-identified as persons in recovery.

Adults in recovery are less likely to be married and more likely to be separated or divorced than adults not self-identified as being in recovery. Adults in recovery are less likely to participate in local community groups and feel social connection with their neighbors. They are also more likely than adults not in recovery to know someone outside their immediate family who is in recovery (52.1% vs. 26.8%), but 47.9% of those adults in recovery did not know another person in recovery. Combined with the finding of generally lower levels of social capital for recovery, this suggests that many SEPA adults are initiating and sustaining recovery without significant general and recovery-specific social support.

Table 2: Family and Social Capital by Recovery Status for SEPA Household Health Survey Respondents (N = 10,006)

Family/Social Capital Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Not Married	67.8%	48.5%	2.2371 (1.919-2.611)
Current Status Divorced or Separated	19.0%	10.5%	2.012(1.666-2.429)
Participate in a Community Group	52.4%	43.9%	1.407 (1.218-1.626)
Neighbors Not Willing to Help	51.8%	61.6%	1.490 (1.287-1.727)
Neighbors can't be Trusted	66.2%	82.0%	2.326 (1.976-2.732)
Don't Feel They Belong in their Neighborhood	83.4%	89.4%	1.678 (1.374-2.049
Know Someone Outside Family in Recovery	52.1%	26.8%	2.973 (2.570-3.440)

Health and Recovery Status A significant portion of adults in recovery from alcohol or other drugs experience continued physical health problems (See Table 3). Nearly one third (35.5%) of adults in recovery describe their health as fair or poor compared with 16.6% of adults not in recovery. SEPA adults in recovery also report higher rates of asthma, diabetes, and high blood pressure as well as higher rates of emergency room visits compared to adults not self-identifying as persons in recovery. Persons in recovery report slightly higher levels of obesity and overweight compared with community members not in recovery.

Table 3: Health Indicators by Recovery Status for SEPA Household Health Survey Respondents (N =10,006)

Health Indicator Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Rating Health as Fair or Poor	35.5%	16.6%	2.778 (2.380-3.236)
Asthma Diagnosis	18.2%	14.4%	1.320 (1.094-1.593)
Diabetes Diagnosis	18.2%	12.2%	1.602 (1.326-1.937)
Physical, Mental, or Emotional Disability	35.9%	13.0%	3.753 (3.208-4.390)
High Blood Pressure	42.5%	35.6%	1.334 (1.153-1.544)
Past Year ER Visit	41.8%	27.3%	1.915 (1.653-2.219)
Overweight or Obese	67.3%	6.8%	1.217 (1.043-1.419)

Access to Healthcare and Recovery Status Adults in recovery from alcohol or other drugs face barriers to healthcare. More adults in recovery (14.2%) report having no regular source of health care (no regular place to go when sick or needing health-related advice) compared with 10.0% of adults not in recovery reporting similar circumstances. Of adults in recovery with a regular source of care, only about two thirds (68.5%) get that care at a doctor's office, with the rest identifying their regular source of care as a community health center, outpatient clinic, emergency department, or other source. In contrast, 87.6% of adults not in recovery identify a doctor's office as their regular source of care.

More than one in five SEPA adults in recovery between the ages of 18 and 64 (22.3%) have no public or private health insurance compared with 10.1% of SEPA adults not in recovery in that same age group. Nearly two thirds of adults in recovery without health insurance (62.7%) have visited an ER rather than a doctor's office for care in the past year because they had nowhere else to go (compared with 49.1% of uninsured adults not in recovery). Adults in recovery with health insurance are more likely to be covered by Medicaid than are insured adults not in recovery (25.7% versus 10.1%). Among adults with health insurance, adults in recovery are more likely than adults not in recovery to have been uninsured at some point in the past year (13.7% as compared with 6.1%).

Recovery Status and Healthcare Screenings Many adults in recovery for alcohol or other drugs forego or delay health care and routine screenings (See Table 4).

As indicated in Table 4, during the past year, adults in recovery were less likely than community members not in recovery to seek health and dental care and to fill needed prescriptions due to their costs. Adults in recovery were less likely to receive a mammogram or prostate exam in the past year, but more likely than other community members to have an HIV test in the past year.

Table 4: Health Care/Screening by Recovery Status for SEPA Household Health Survey Respondents (N =10,006)

Health Care/Screening Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Did not Seek Needed Care in Past Year Due to Cost	20.4%	10.2%	2.254 (1.875-2.709)
Did not Get Needed Prescription Due to Cost	25.2%	14.6%	1.963 (1.658-2.325)
Did not Get Dental Care Due to Cost	37.6%	21.4%	2.210 (1.900-2.571)
Women Getting No Mammogram in Past Year	39.4%	34.4%	1.237(.969-1.579)
Men Getting No Prostate Exam in Past Year	53.9%	39.9%	1.760 (1.387-2.232)
No HIV Testing in Past Year	68.9%	82.2%	.480 (.409-.564)

Recovery Status and Management of Health Risks Many adults in recovery have health-related behaviors that increase their risk of disease (See Table 5). More than four in five adults in recovery (81.5%) have been cigarette smokers compared with 43.7% of adults not in recovery. Nearly half of adults in recovery (49.4%) currently smoke compared to only 17.0% of adults not in recovery. Adult smokers in recovery also smoke more than smokers not in recovery. In Philadelphia, for example, smokers in recovery are more likely than other smokers to smoke a pack or more per day (41.0% compared with 32.4%). More than half (58.5%) of smokers in recovery tried to quit smoking during the past year—most (54.3%) via cold turkey, with only 29.8% using nicotine replacement therapy (Malinowski Weingartner et al., 2011). Nearly three in ten adults in recovery (26.8%) reported in the SEPA survey that somebody smokes inside their home compared with 11.5% of adults not in recovery. The health risks of people in recovery also extend to the arenas of exercise and diet, e.g., not exercising at all (16.5% of adults in recovery versus 11.4% of adults not in recovery), not eating any daily servings of fruit (7.2% versus 2.7%), and eating fast food three or more times per week (10.6% versus 5.7%).

Table 5: Behavioral Risk Factors and Recovery Status for SEPA Household Health Survey Respondents (N = 10,006)

Behavioral Risk Measure	Persons in Recovery	Persons not in Recovery	Odds Ratio (CI)
Lifetime Smoking	81.5%	43.7%	5.689 (4.740-6.829)
Current Smoking	49.4%	17.0%	4.757 (4.101-5.519)
Exposed to Smoke in Home	26.8%	11.5%	2.826 (2.388-3.344)
Report no Regular Exercise	16.5%	11.4%	1.541 (1.266-1.876)
Report no Daily Serving of Fruit	7.2%	2.7%	2.805 (2.077-3.788)
Report Fast Food 3 or More Times per Week	10.6%	5.7%	1.953 (1.536-2.484)

Access to other Health Resources and Recovery Status Many adults in recovery have limited access to the resources they need in order to make healthy choices. Nearly one in five (19.9%) adults in recovery reported that the quality of groceries in their neighborhood is fair or poor compared to 11.9% of adults not in recovery. One third of adults in recovery (33.1%) have to travel outside their neighborhood to go to a supermarket compared with 28% of adults not in recovery.

Emotional Health and Recovery Status Many adults in recovery are affected by psychological and emotional difficulties. More than one in three adults in recovery (38%) have been diagnosed with a mental health condition compared to only 12.3% of adults not in recovery. Nearly two thirds of adults in recovery who have a mental health condition (66.2%) receive treatment for that mental health condition—greater than the 60.2% of adults not in recovery that receive treatment for a diagnosed mental health condition(s). More than one in five adults in recovery (21%) report experiencing an extreme amount of stress compared to only 9.1% of adults not in recovery.

Discussion

Limitations. Past epidemiological studies that have attempted to measure the prevalence of recovery in the general population have relied on the measure of remission—the prevalence of persons reporting meeting lifetime SUD diagnostic criteria but not past year SUD diagnostic criteria (Compton et al. 2007; Dawson 1996; Dawson et al. 2008, 2005; Kessler et al. 1994; Hasin et al. 2007; Hasin et al. 1997; Hasin & Grant 1995; Robins, Locke, & Regier 1991). Such study designs are expensive and difficult to replicate for cities and counties wishing to use recovery prevalence data for planning and evaluation purposes. DBHIDS and PHMC added a small number of questions to an existing public health survey instrument, and defined recovery as an affirmative response to the question: "Did you once have an alcohol or other drug problem that is no longer a problem in your life?"—a question similar to that recently used in the Partnernship OASAS recovery prevalence study (Feliz 2012). Without SUD

diagnostic criteria or other measures of problem severity embedded within the survey questions, it is quite possible that aggregate affirmative responses to this question inflate the estimate of adults "in recovery" by including persons with transient subclinical, AOD-related problems. Responses to questions about recovery status may be affected by social desirability bias, resulting in an under-reporting of recovery status. Aggregate negative responses to the question could also be deflated by the inclusion of persons in recovery who, though in remission and/or abstinent, continue to see themselves as having an alcohol or other drug problem that needs active management on par with other chronic disorders such as asthma, diabetes or heart disease. Defining recovery using a single factor (remission/ problem resolution) also belies the increased understanding of recovery as a multidimensional state.

The category of persons not reporting recovery status in the SEPA survey is also ambiguous in that it includes people who have never used alcohol or drugs, people who have used alcohol or drugs without self-perceived problems, people who have present and continuing AOD problems, and people who once had but no longer have AOD problems but choose not to self-identify that status. These categorical ambiguities limit study conclusions.

Recovery Prevalence. Three questions related to recovery from alcohol and other drug problems were added to the 2010 Southeastern Pennsylvania (SEPA) health survey. Of the more than 10,000 individuals interviewed, 9.45% of survey respondents reported having had an alcohol or drug problem that was no longer a problem in his or her life. This compares to rates of SUD remission reported in national epidemiological studies (10.8%; Kessler, et al. 2005a,b), combined rates for separate studies of alcohol and drug use disorder remission rates (5.3%; Dawson et al. 2008; 8.3%; Compton et al. 2007), and the rate from a just-released national telephone survey of recovery prevalence whose wording of the key recovery status question was close to that used in the SEPA survey (10%; Feliz 2012). Caution is warranted in thinking of the categories of "in recovery" and "not in recovery" as fixed states. Studies of clinical populations show a high degree of movement between these states in the three years following addiction treatment (Scott, Foss, & Dennis 2005), and studies of "natural recovery" (recovery without aid of professional treatment) in community populations also reveal such early instability (Moos & Moos 2005). Measuring time in recovery in future cross-sectional surveys of recovery prevalence would add a dimension that could have great import to planning local recovery support services across the stages of recovery.

What is clear from the present study and the national epidemiological studies of recovery is that there is a large population of people in recovery who could be potentially mobilized to promote recovery-focused social policies and expand local recovery support services (White 2009a)—a process that is already underway in many U.S. communities (White 2007b).

Demography of Recovery. The demographic profile of those in recovery in SEPA is similar to that reported in a recent national survey of adults in recovery (Feliz 2012). People in recovery are more likely to be male than female and more likely to be middle aged than a young or older adult. The dominance of middle-age recovery prevalence is congruent with the concept of addiction/treatment careers and the progressive acceleration of AOD use and related consequences that often precede recovery initiation (Anglin et al. 2001). The lower recovery representation among older adults may represent generational patterns of AOD problem development, age-related rates of recovery initiation, and age-related differences in comfort in self-reporting recovery

status. It could also reflect attrition in recovery prevalence in the transition from middle adulthood to older adulthood via erosion of recovery stability during late life transitions or a higher mortality rate of people in recovery (Scott et al. 2011; Gossop et al. 2002; Hser et al. 2001; Zanis & Woody 1998; Edwards 1989). Comparing demographic data related to AOD problems with the demographic profile of people in recovery could help policy makers target recovery support resources to locations and populations in greatest need of services.

Family and Social Recovery Capital. The SEPA study revealed that adults in recovery are less connected to family, neighborhood, and community life than adults not in recovery. This could reflect the damage done to family, social, and community relationships as a consequence of excessive and prolonged AOD use and the effects of social stigma on community re-integration during recovery. This would suggest the value of community-based recovery support services specifically focused on repair of relationships with family and kinship networks and guidance through the transitions from cultures of drug use to cultures of recovery to recovery-supportive relationships within the larger community (White 2009b).

A striking finding was that 47.2% of SEPA adults in recovery reported not knowing another person in recovery outside their family. Studies of recovery in treated populations have underscored the role of general social support and recovery-specific support in enhancing long-term outcomes (Groh et al. 2007; Laudet, Morgen, & White 2006; McCrady 2004; Broome, Simpson, & Joe 2002; Beattie & Longabaugh 1999; Humphreys, Moos, & Cohen 1997). The SEPA study suggests that many people are sustaining SUD recovery without participation in the peer-based mutual support available in most treatment settings and in all recovery support groups.

Recovery Health Profile. While mortality rates among persons treated for SUDs decline and many areas of personal and social functioning improve with sustained abstinence (Hibbert & Best 2011; Scott et al. 2011), it is clear that many people entering recovery bring burdens of impaired physical and emotional health and social isolation that can compromise their future quality of life as well as their life expectancies. SEPA adults in recovery, compared to those not identifying recovery status, report greater health-related problems, greater barriers in seeking health care, greater risk behaviors associated with chronic health problems, and less social capital to manage the effects of such problems.

The prevailing acute care model of addiction treatment rests on the assumption that the transition from recovery initiation to stable recovery maintenance and concomitant improvements in global health and social functioning will continue following addiction treatment without continued professional monitoring and support. High rates of post-treatment resumption of AOD use (more than 50% as reviewed by White 2008b) following addiction treatment and the quality of life data from the present survey challenge this assumption. There have been growing calls to extend addiction treatment from an acute care model of intervention to models of sustained recovery management, particularly for those persons with the most severe, complex, and chronic SUDs (Dennis & Scott 2007; McLellan, Lewis, O'Brien, & Kleber 2000; White 2008b). The primary purpose of such advocacy has been to ensure post-treatment recovery stabilization and maintenance. The present survey results suggest a different agenda: reducing addiction-related burdens brought into the recovery process and enhancing quality of life and health in long-term recovery for treated and untreated populations in recovery. The increased integration of primary health care, mental health care, and

addiction treatment inherent in current health care reforms may offer increased opportunities for achieving these multiple goals (Mechanic 2012; Buck 2011).

The role smoking (nicotine addiction) plays in increased morbidity and mortality of people in recovery from other SUDs deserves intensified attention in the addictions field. The SEPA survey reveals a high rate of smoking among people in recovery, chronic health conditions associated with smoking, and a desire and efforts by people in recovery to quit smoking. Other studies of people with past or present SUDs confirm high rates of smoking, heavy smoking, smoking-related diseases, and smoking-related mortality (Hurt, et al. 1996; Hser, McCarthy, & Anglin 1994). These findings in tandem with evidence that smoking cessation improves recovery outcomes for other drug dependencies (Kalman et al. 2010; Prochaska, Delucchi, & Hall 2004; Kohn, Tsoh, & Weisner 2003) have triggered efforts to integrate smoking cessation into addiction treatment (Knudsen et al. 2010). The SEPA study confirms the need for such efforts and for similar community-based efforts to support smoking cessation among people in recovery who are not involved in addiction treatment.

*Recovery Status and Barriers to Health Care. A*dults in recovery reported less access and utilization of health care resources than adults not reporting recovery status. The reduced access to regular health care and prescription medications reported by people in recovery is likely linked to lower income levels and lower levels of public and private health insurance coverage. Combined with reports of behavioral risks related to smoking and inadequate diet and exercise, these findings suggest that models of sustained recovery management integrate on-site primary health care or assertive linkage to primary health care within their service protocols.

Future Research. Regular replications of recovery surveys could examine recovery prevalence changes over time by key demographic variables, the influence of professional treatment, recovery mutual aid, or alternative recovery support mechanisms, and the prevalence of particular recovery pathways and styles of recovery. *Conclusions.* Questions related to the resolution of AOD problems can be added to existing community surveys to provide valuable information for service system planning and evaluation. This five-county Southeastern Pennsylvania population survey of recovery from AOD problems adds to the body of studies documenting a significant population of adults (approximately 10% of the adult population) who have experienced and subsequently resolved an AOD problem. The finding that people in recovery experience greater health problems, greater obstacles to health care, and greater behavioral risks predictive of compromised health and life expectancies than other community members calls for integrating primary health care into strategies of long-term recovery management for both treated and untreated populations seeking to resolve AOD-related problems. This study confirms the value of conceptualizing addiction as a chronic disorder not just in terms of the often long course of active drug use and the frequent cycles of remission and reoccurrence, but also for the physical, emotional, and social legacies that extend far into the long-term personal and family recovery processes.

Problems of physical health and problems of compromised personal assets (specifically in the arenas of education, employment, income, housing, and health insurance), family alienation, and social marginalization do not spontaneously remit on the heels of recovery initiation. Existing models of professional and peer interventions may open the doorway to recovery, but new models are needed to help people achieve and sustain global health and positive community reintegration in long-term recovery.

References

Achara-Abrahams, I.; Evans, A.C. & King, J.K. 2011. Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In: J.F. Kelly & W.L. White (Eds.) *Addiction Recovery Management: Theory, Science and Practice*. New York: Springer Science.

Anglin, M.D.; Hser, Y.; Grella, C.; Longshore, D. & Prendergast, M. 2001. Drug treatment careers: Conceptual overview and clinical research, and policy applications. In: F. Tims; C. Leukefeld & J. Platt (Eds.) *Relapse and Recovery in Addictions*. New Haven: Yale University Press.

Anthony, W.A. 2000. A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal* 24 (2): 159-168.

Beattie, M.C. & Longabaugh, R. 1999. General and alcohol-specific social support following treatment. *Addictive Behaviors* 24 (5): 593-606.

The Betty Ford Institute Consensus Panel. 2007. What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment* 33 (3): 221-228.

Broome, K.M.; Simpson, D.D. & Joe, G.W. 2002. The role of social support following short-term inpatient treatment. *American Journal on Addictions* 11 (1): 57-65.

Buck, J.A. 2011. The looming expansion and transformation of public substance abuse treatment under The Affordable Care Act. *Health Affairs* 30 (8): 1402-1410.

Compton, W.M.; Thomas, Y.F.; Stinson, F.S. & Grant, B.F. 2007. Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry* 64 (5): 566-576.

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* 34 (2): 109-120.

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.

Dawson, D.A.; Grant, B.F.; Stinson, F.S.; Chou, P.S.; Huang, B. & Ruan, W.J. 2005. Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction* 100 (3): 281-292.

Dawson, D.A.; Stinson, F.S.; Chou, S.P. & Grant, B.F. 2008. Three-year changes in adult risk drinking behavior in relation to the course of alcohol-use disorders. *Journal of Studies on Alcohol and Drugs* 69 (6): 866-877.

De Soto, C.B.; O'Donnell, W.E. & De Soto, J.L. 1989. Long-term recovery in alcoholics. *Alcoholism: Clinical and Experimental Research* 13 (5): 693-697.

Dennis, M. & Scott, C.K. 2007. Managing addiction as a chronic condition. *Addiction Science & Clinical Practice* 4 (1): 45-55.

Edwards, G. 1989. As the years go rolling by: Drinking problems in the time dimension. *British Journal of Psychiatry* 154 (1): 18-26.

El-Guebaly, N. 2012. The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine* 6 (1): 1-9.

Evans, A.C. 2007. The recovery-focused transformation of an urban behavioral health care system: An interview with Arthur Evans, PhD. In: W.L. White (Ed.)

Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-oriented System of Care. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Feliz, J. 2012. *Survey: Ten Percent of American Adults Report Being in Recovery from Substance Abuse or Addiction. The Partnership at Drugfree.org and The New York State Office of Alcoholism and Substance Abuse Services*. Retrieved July 17 from: http://www.drugfree.org/newsroom/survey-ten-percent-of-american-adults-report-being-in-recovery-from-substance-abuse-or-addiction

Gagne, C.; 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.

Gerard, D.L.; Sanger, G. & Wile, R. 1962. The abstinent alcoholic. *Archives of General Psychiatry* 6 (1): 83-95.

Gossop, M.; Stewart, D.; Treacy, S. & Marsden, J. 2002. A prospective study of mortality among drug misusers during a 4-year period after seeking treatment. *Addiction* 97 (1): 39-47.

Groh, D.R.; Jason, L.A.; Davis, M.I.; Olson, B.D. & Ferrari, J.R. 2007. Friends, family, and alcohol abuse: An examination of general and alcohol-specific social support. *The American Journal on Addictions* 16 (1): 49-55.

Hasin, D.S. & Grant, B.F. 1995. AA and other helpseeking for alcohol problems: Former drinkers in the U.S. general population. *Journal of Substance Abuse* 7 (3): 281-292.

Hasin, D.S.; Stinson, F.S.; Ogburn, E. & Grant, B.F. 2007. Prevalence, correlates, disability and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from the National Epidemiologic Survey on Alcohol and related conditions. *Archives of General Psychiatry* 64 (7): 830-842.

Hasin, D.S.; Van Rossem, R.; McCloud, S. & Endicott, J. 1997. Differentiating DSM-IV alcohol dependence and abuse by course: Community heavy drinkers. *Journal of Substance Abuse* 9: 127-135.

Hibbert, L.J. & Best, D.W. 2011. Assessing recovery and functioning in former problem drinkers at different stages of their recovery journeys. *Drug and Alcohol Review* 30 (1): 12-20.

Hser, Y-I.; Hoffman, V.; Grella, C.E. & Anglin, M.D. 2001. A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry* 58 (5): 503-508.

Hser, Y.I.; McCarthy, W.J. & Anglin, M.D. 1994. Tobacco use as a distal predictor of mortality among long-term narcotics addicts. *Preventive Medicine* 23 (1): 61-69.

Humphreys, K.; Moos, R.H. & Cohen, C. 1997. Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol* 58 (3): 231-238.

Hurt, R.D.; Offord, K.P.; Croghan, I.T.; Gomez-Dahl, L.; Kottke, T.E.; Morse, R.M. & Melton, J., III. 1996. Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. *Journal of the American Medical Association* 274 (14): 1097-1103.

Kalman, D.; Kim, S.; DiGirolamo, G.; Smelson, D. & Ziedonis, D. 2010. Addressing tobacco use disorder in smokers in early remission from alcohol dependence: The case for integrating smoking cessation services in substance use disorder treatment programs. *Clinical Psychology Review* 30 (1): 12-24.

Kessler, R.C.; Berglund, P.; Demler, O.; Jin, R.; Merikangas, K.R. & Walters, E.E. 2005a. Lifetime prevalance and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* 62 (6): 593-603.

Kessler, R.C.; Chiu, W.T.; Demier, O. & Walters, E.E. 2005b. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorobity Survey replication. *Archives of General Psychiatry* 62 (6): 617-627.

Kessler, R.C.; McGonagle, K.A.; Zhao, S.; Nelson, C.B.; Hughes, M.; Eshelman, S.; Wittchen, H.U. & Kendler, K.S. 1994. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry* 51 (1): 8-19.

Knudsen, H.K.; Studts, J.L.; Boyd, S. & Roman, P.M. 2010. Structural and cultural barriers to the adoption of smoking cessation services in addiction treatment organizations. *Journal of the Addictive Diseases* 29 (3): 294-305.

Kohn, C.S.; Tsoh, J.Y. & Weisner, C.M. 2003. Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. *Drug and Alcohol Dependence* 69 (1): 61-71.

Laudet, A.B. 2008. The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Substance Use & Misuse* 43 (12-13): 2001-2020.

Laudet, A.B. 2007. What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment* 33 (3): 243-256.

Laudet, A.B.; Morgen, K. & White, W.L. 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 problems. *Alcoholism Treatment Quarterly* 24 (1-2): 33-73.

McCrady, B.S. 2004. To have but one true friend: Implications for practice of research on alcohol use disorders and social network. *Psychology of Addictive Behaviors* 18 (2): 113-121.

McLellan, A.T.; Lewis, D.C.; O'Brien, C.P. & Kleber, H.D. 2000. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association* 284 (13): 1689-1695.

McLellan, T. 2010. What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment* 38 (2): 200-201.

Mechanic, D. 2012. Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Affairs* 31 (2): 376-382.

Moos, R.H. & Moos, B.S. 2005. Sixteen-year changes and stable remission among treated and untreated individuals with alcohol use disorders. *Drug and Alcohol Dependence* 80 (3): 337-347.

Pattison, E.M.; Headley, E.B.; Gleser, G.C. & Gottschalk, L.A. 1968. Abstinence and normal drinking: An assessment of change in drinking patterns in alcoholics after treatment. *Quarterly Journal of Studies on Alcohol* 29 (3): 610-633.

Prochaska, J.J.; Delucchi, K. & Hall, S.M. 2004. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology* 72 (6): 1144-1156.

Ralph, R. & Corrigan, P. (Eds.) 2004. *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington DC: American Psychological Association.

Robins, L.N.; Locke, B.Z. & Regier, D. 1991. An overview of psychiatric disorders in America. In: L.N. Robins & D.A. Regier (Eds.) *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. New York: The Free Press.

SAMHSA. 2011. *SAMHSA's Working Definition of Recovery Updated*. Retrieved July 20, 2012 from http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

Scott, C.K.; Dennis, M.L.; Laudet, A.; Funk, R.R. & Simeone, R.S. 2011. Surviving drug addiction: The effect of treatment and abstinence on mortality. *American Journal of Public Health* 101 (4): 737-744.

Scott, C.K.; Foss, M.A. & Dennis, M.L. 2005. Pathways in the relapse—treatment—recovery cycle over 3 years. *Journal of Substance Abuse Treatment* 28 (Supplement 1): S63-S72.

U.S. Census Bureau (2012) USA Quick Facts from the US Census Bureau: Department of Commerce. Accessed October 16 at http://quickfacts.census.gov/qfd/states/00000.html

Weingartner, R.M.; Minot, K.O.; Coughey, K.; Gutierrez, M. & Kotranski, L. 2011. *Smoking Cessation Among Persons with Behavioral Health Issues*. Presented at the American Public Health Association Meeting, Washington D.C., October 31, 2012. Retrieved July 18, 2012 from https://apha.confex.com/apha/139am/webprogram/Paper244419.html

White, W.L. 2012. *Recovery/remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Studies, 1868-2011*. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual disAbility Services Mental Retardation Services and Northeast Addiction Technology Transfer Center.

White, W.L. 2009a. The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment* 36 (2): 146-158.

White, W.L. 2009b. *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W.L. 2008a. Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse* 43 (12&13): 1987-2000.

White, W.L. 2008b. *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.L. 2007a. Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment* 33 (3): 229-241.

White, W.L. 2007b. The new recovery advocacy movement in America. *Addiction* 102 (5): 696-703.

White, W.L. 2007c. *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-oriented System of Care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W.L. 2005. Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly* 23 (1): 3-15.
Zanis, D.A. & Woody, G.E. 1998. One-year mortality rates following methadone treatment discharge. *Drug and Alcohol Dependence* 52 (3): 257-260.

The Role of Harm Reduction in Recovery-oriented Systems of Care: The Philadelphia Experience

Arthur C. Evans, Jr., PhD, William L. White, MA, and Roland Lamb, MA

While harm reduction can be viewed as an end in itself with a focus on mitigating harm to individuals, families and the community as a whole, harm reduction strategies can also be viewed collectively as a platform or point of access for promoting long-term health, and, for those with severe alcohol and other drug problems, long-term personal and family recovery. If our goal is to promote health and reclaim lives, then we must understand the direct and sometimes circuitous paths through which individuals and families achieve and sustain such health. We must meet each individual and family with fresh eyes in every encounter with a belief that each encounter is an opportunity for movement, no matter how small, towards health and wholeness. –Arthur C. Evans, Jr., 2013[1]

Bridging the harm reduction and traditional addiction treatment and recovery worlds *"requires openness to the possibility that our worldview and the cherished concepts we use to describe it may need to become subtler, more fine-grained, amended or even discarded; and, that approaches which don't work for one person can, equally, be life-saving for others, when all the time our own beliefs, experiences, perhaps even our entire biography, shouts out that this can't be so."* –Neil Hunt, 2012[2]

Executive Summary

In the United States, advocates of abstinence-based addiction treatment/recovery (AATR) and advocates of harm reduction (HR) have staked out opposing turf in one of the most polarized debates within the history of the alcohol and other drug (AOD) problems arena. The purpose of the present paper is not to add a new chapter in this ongoing debate but rather to transcend the debate by exploring areas of common ground upon which integration of AATR and HR approaches have been achieved over the past decade within the City of Philadelphia's recovery-focused behavioral health systems transformation process.

Harm Reduction Basics

Harm reduction (HR) is a philosophy and menu of services aimed at minimizing injury to self, others, and community by AOD consumers—from the most casual users to those with the most severe drug dependencies. HR service programs include promotion

[1] Personal Communication with Arthur C. Evans, Jr. May 3, 2013.
[2] Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell.

and support for safer AOD use practices and provision of medical and social support to AOD users, including linkage to addiction and psychiatric treatment resources. The goal of HR has also historically shaped the design of particular treatment interventions, e.g., methadone maintenance and other maintenance pharmacotherapies. HR as policy, philosophy, and service menu has been profoundly shaped by the goals of reducing AOD-related transmission of HIV/AIDS and viral hepatitis and AOD overdose deaths, e.g., the development of needle and syringe exchange programs, medically supervised safer injection rooms, although HR as a philosophy targets much broader patterns of AOD use and related harms. Whether the focus of the HR movement should be on person- and population-focused public health interventions or broader advocacy of user rights and changes in drug policy (e.g., drug decriminalization or legalization) continues to be debated within the HR movement.

Harm Reduction and Abstinence-based Addiction Treatment/Recovery

In the vitriolic HR/AATR debates, radical abstentionists have contended that HR programs 1) divert funds that could be used to expand abstinence-based treatment, 2) prolong drug use/addiction careers, 3) encourage new drug users via a message of drug tolerance, and 4) are a "Trojan horse" masking the goal of drug legalization. Radical harm reductionists, in turn, have argued that traditional AATR programs: 1) do not voluntarily attract the majority of people with severe AOD problems, 2) use methods that are disrespectful and harmful, 3) refuse to admit patients who are on medications for psychosocial support services, 4) refuse to acknowledge the recovery status of medication-stabilized patients, 5) kick people out of treatment and/or deny readmission for becoming symptomatic (e.g., drug use), and 6) are a modern throwback of early religious and temperance movements. Mutual antagonisms across the HR/AATR chasm are slowly giving way to more reasoned communications and collaborations. Experiments in integrating HR and AATR are proceeding across the U.S. and internationally at both conceptual and practice levels.

AATR and HR in the City of Philadelphia

Through the leadership of the Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS) / Office of Addiction Services (OAS), the City of Philadelphia has championed the integration of AATR and HR services as part of the larger recovery-focused systems transformation process initiated in 2004. Over the past decade, the systems transformation process has moved the relationships between Philadelphia's AATR and HR programs from a stance of isolation, mutual suspicion, conflict, and competition for public support and resources to a stance of increased dialogue and collaboration.

HR and AATR Integration Profiles

AATR/HR integration is evident in four primary areas within the transformation of Philadelphia's behavioral health care system: 1) assertive outreach and low-threshold service access points, 2) recovery-oriented methadone maintenance, 3) needle and

syringe exchange programs that integrate both HR and recovery goals and principles, and 4) a housing continuum that includes wet, damp, and dry housing support resources.

Key Understandings about the Course and Consequences of AOD Use and Related Problems and Their Resolution Process

AATR/HR integration efforts in Philadelphia have been built on a number of key understandings.

- HR-oriented services can preserve life during periods of active drug use and reduce the burdens on self, family, and community brought into a subsequent recovery process.
- Both AATR and HR programs have the responsibility of enhancing coping methods and increasing social supports as AOD use decelerates or ceases. Such supports are critical to prevent inadvertent harm resulting from the service intervention.
- Integrated AATR and HR principles and practices provide a way to reach, engage, and support positive change across the arenas of drug use, addiction, and recovery.
- AATR and HR represent not opposing strategies but approaches to reaching different populations and reaching the same individuals at different stages of their AOD use, addiction, and recovery careers.
- Integrated AATR and HR principles and practices are particularly important for addressing multiple, severe, complex, and chronic (often intergenerational) problems.
- Shifts in drug choice and changes in the frequency, methods of administration, and contexts for use can be viewed within an "all or none" view of addiction recovery or viewed as incremental experiments in problem resolution that constitute an important "recovery priming" process.
- Resistance and ambivalence are a natural—not pathological—response to internal and external pressure to change deeply engrained behaviors.
- Resistance and ambivalence are reduced when people have real choices and are empowered to choose.
- Recovery can be achieved with or without medication support—including recovery from opioid addiction with or without methadone or buprenorphine.

- Defining recovery as contingent upon cessation of medications such as methadone or buprenorphine flies in the face of scientific evidence and clinical experience and creates a "hierarchy of worthiness" that feeds stigma and discrimination against people in medication-assisted recovery.

Lessons from AATR and HR Integration Experiments

Philadelphia's AART/HR integration efforts have been based on a more nuanced understanding of the course and consequences of AOD use and related problems and how such problems can be managed and resolved as well as lessons learned about how integration efforts can best be facilitated. Thirteen such lessons are discussed:

1. AATR and HR integration is not easy.
2. Both AATR and HR as models of intervention must be publicly and professionally defended through the integration process.
3. Leadership and strategy at multiple levels are essential.
4. Ideas matter. AATR/HR integration involves processes of conceptual stretching within both the AATR and HR communities.
5. Science helps, but stories and direct experience are essential.
6. Relationships matter. AATR/HR integration involves relationship building and relationship maintenance across systems boundaries.
7. Money and public/professional recognition matter. AATR/HR integration must address issues of personal/professional/institutional interests that inhibit collaboration.
8. HR and AATR collaborations can be a win/win process.
9. HR and AATR are not either/or options.
10. Drug users may be viewed as "incompetent and pathological" and thus only "objects of intervention" or as "allies and participants in their own individual and collective health."
11. Recovery initiation is about a synergy of pain and hope.
12. AATR and HR are the products of heterogeneous social movements made up of constituency groups with widely varying philosophies and service practices, all of whom cannot be expected to approve of or participate in processes of collaboration.
13. HR and AATR integration must be bi-directional.

Conclusions

The chasm between HR and AATR principles and practices is being bridged with hybrid approaches that integrate public health and clinical perspectives. Such integration may constitute the future for the management of the most severe, complex, and chronic AOD problems.

The Role of Harm Reduction in Recovery-oriented Systems of Care: The Philadelphia Experience

Harm reduction (HR), also referred to as harm minimization, rose to prominence in the 1980s and 1990s as a new organizing framework within the alcohol and drug (AOD) problems and larger public health arenas. Spawned in great measure by alarm over rising rates of HIV, HBV, and HCV infections,[3] HR garnered considerable international support, but also generated heated opposition, particularly within the United States. While discussions of HR often deteriorated into "stale, endless and unproductive arguments between radical abstentionists and militant harm reductionists,"[4] there are indications of movement beyond such polarized positions. Opposition to HR may be softening in the U.S. among addiction professionals, recovery advocates, and within particular local communities,[5] even as more substantive critiques of HR emerge within the U.K. and Australia where harm reduction has been pursued as a central policy.[6] In the past decade, recovery has also emerged as a conceptual framework for the redesign of addiction treatment and the emergence of new recovery support services within the U.S. and U.K.[7]

The confluence of these trends raises questions about the extent to which the HR and recovery organizing frameworks represent competing or complementary paradigms and, more importantly, if and how such orientations can be best integrated at the frontlines of local service planning and delivery. The purpose of the present paper is to describe how principles and practices of abstinence-based addiction treatment/recovery (AATR) and HR have been integrated over the past decade within the City of Philadelphia's recovery-focused behavioral health systems transformation process.

Harm Reduction Basics

HR represents both a philosophy and a menu of service programs.[8] HR programs extol the value of practical strategies for minimizing harm among those who continue to

---

[3] Stimson, G. V. (2007). "Harm Reduction—Coming of Age": A local movement with global impact. *International Journal of Drug Policy*, *18*, 67-69. doi:10.1016/j.drugpo.2006.12.012

[4] Humphreys, K. (2010). British drug and alcohol policy: V. What is "recovery" from addiction, and can medications be part of it? Retrieved May 7, 2013 from http://www.samefacts.com/2010/09/drug-policy/british-drug-and-alcohol-policy-v-what-is-%E2%80%9Crecovery%E2%80%9D-from-addiction-and-can-medications-be-a-part-of-it/

[5] White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center.; White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, *11*(6), 44-53.

[6] McKeganey, N. (2012). Harm reduction at the crossroads and the rediscovery of drug user abstinence. *Drugs: Education, Prevention, and Policy*, *19*(4), 276-283. doi:10.3109/09687637.2012.671867; Miller, P. G. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health*, *11*(2), 167-178. doi:10.1080/09581590110039865

[7] Berridge, V. (2012). The rise, fall, and revival of recovery in drug policy. *Lancet*, *379*, 22-23. doi:10.1016/S0140-6736(12)60011-7; El-Guebaly, N. (2012). The meanings of recovery from addiction: Evolution and promises. *Journal of Addiction Medicine*, *6*(1), 1-9. doi:10.1097/ADM.06013e31823ae540; Home Office. (2010). *Drug Strategy 2010. Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life*. London: Home Office. Wardle, I. (2012). Five years of recovery: December 2005 to December 2010—From challenge to orthodoxy. *Drugs: Education, Prevention and Policy*, *19*(4), 294-298. doi:10.3109/09687637.2012.671866; UKDPC. (2008). *A vision of recovery*. UK Drug Policy Commission. White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly*, *23*(1), 3-15. doi:10.1300/J020v23n01_02

[8] Stimson, G. V. (2007). "Harm Reduction—Coming of Age": A local movement with global impact. *International Journal of Drug Policy*, *18*, 67-69. doi:10.1016/j.drugpo.2006.12.012

use alcohol and/or other drugs—strategies that address harm to individual users, their families, and the community as a whole. This is evident in programs seeking to reduce harm without seeking to diagnose or treat addiction as well as in programs that provide HR services while encouraging incremental changes toward long-term recovery and wellness for those with severe AOD problems.[9] While many HR advocates also assert the rights of drug users to freedom from persecution, this is more an allied theme rather than a central Pillar of HR, although tension continues to exist within the HR movement as to whether the movement's primary focus should be a public health or user rights agenda.[10]

HR programs view interventions within a "hierarchy of harm" framework and view reduction of harm related to AOD use as a more important and realistic goal than preventing or reducing AOD use.[11] Such a "hierarchy of harm" could be reflected in the acts of reducing the frequency of needle and syringe sharing, ceasing all needle and syringe sharing, reducing the frequency of drug injections, ceasing drug injections, reducing illicit drug use, ceasing illicit drug use, experimenting in abstinence, and achieving stable abstinence from all drug use. Within the HR framework, each such step is viewed as a valuable achievement in its own right.

Historically, "harm reduction neither excludes nor presumes the long-term treatment goal of abstinence."[12] The HR concern has been with the potential fragility of abstinence and the harm accruing to individuals, families, and communities when abstinence is lost. For example, HR advocates do not deny the ability of particular individuals to move from injection drug use to stable recovery, but question the probabilities of sustained abstinence for the larger population of injection drug users. It's a question of probabilities and creating safety nets when abstinence deteriorates into active drug use. Alan Marlatt,[13] an early HR leader, consistently noted that sustained abstinence was the ultimate harm reduction strategy, but some HR advocacy groups today are less likely to include abstinence support within HR strategies and more likely to assert drug use as a right.

> *Harm reduction is about active drug use. Harm reduction is the goal—not a step along the 'road to recovery' or the path to 'freedom from dependence'. It is not, cannot and was never meant to be a point on a 'continuum' towards the 'real' goal of abstinence and a drug-free lifestyle.*[14]

---

[9] Lenton, S., & Single, E. (1998). The definition of harm reduction. *Drug & Alcohol Review*, *17*, 213-220. doi:10.1080/09595239800187011; Zelvin, E., & Davis, D. R. (2001). Harm reduction and abstinence based recovery: A dialogue. *Journal of Social Work Practice in the Addictions*, *1*(1), 121-133. doi:10.1300/J160v01n01_09

[10] Hunt, N. (2004). Public health or human rights: What comes first? *The International Journal of Drug Policy*, *15*, 231-237. doi:10.1016/j.drugpo.2004.02.001

[11] Harm Reduction International. (2013). What is harm reduction?" Retrieved March 16, 2013 from http://www.ihra.net/what-is-harm-reduction; Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use*, *18*, 56-64. doi: 10.3109/14659891.2013.761024.

[12] Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from http://www.forward-thinking-on-drugs.org/review2-print.html

[13] Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors*, *21*(6), 779-788. doi:10.1016/0306-4603(96)00042-1; Marlatt, G. A. (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York: Guildford Press.

[14] AIVL. (2012). *'New recovery', harm reduction & drug use policy statement*. Australian Injecting & Illicit Drug Users League. Retrieved May 8, 2013 from http://aivl.org.au/database/sites/default/files/New%20Recovery,%20Harm%20Reduction%20%26%20Drug%20Use%20-%20AIVL%20Policy%20Position%20Paper.pdf

As we shall see in the coming pages, the issue of where abstinence and recovery support fits, and if it fits at all, into the HR service rubric is in a state of flux, as are the questions of if and how HR-oriented services can be integrated into traditional AATR programs.

Programmatically, HR is associated internationally with a wide spectrum of programs and services that are illustrated in Table 1.

Table 1: Spectrum of Harm Reduction Programs/Services

- Seatbelt, designated driver programs, breath alcohol ignition interlock devices
- Alcohol server training programs
- Education/coaching/treatment to support moderation of high risk drinking
- Testing of illicit drug samples and dissemination of information to users regarding misrepresentation and adulteration of illicit drugs
- HR-focused street outreach programs aimed at lowering risk behaviors of AOD users, particularly injection drug users
- Organizing injection drug users for AIDS prevention, mutual support, and inculcation of safer injection and safer sex practice, e.g., reshaping norms within the injection subculture[15]
- Social marketing of safer methods of drug use (encouragement for lower risk drug choice, dosages, frequency of use, routes of administration [i.e., non-injecting routes of administration], and settings for use)
- Needle and Syringe Exchange Programs, e.g., distribution of safer injection supplies (syringes, cookers, alcohol pads, cotton filters, water, bleach, antibiotic ointment, band aids) and safer sex supplies (male and female condoms, dental dams)
- Medically supervised safer injection rooms/centers
- Resources or sites for safe needle disposal
- Medical services for active users (e.g., first aid, HIV testing, and counseling)
- Education on safer injection techniques, needle and syringe disposal, and vein care
- Hepatitis B vaccination programs
- Distribution of bleach kits, condoms
- Overdose prevention and intervention programs (naloxone distribution and training), including family education on overdose management
- Linkage to addiction treatment and recovery support resources
- Advocacy for inclusion of active drug users in treatment activities
- Methadone maintenance & other maintenance pharmacotherapies
- Housing First Programs (housing not contingent on abstinence, including "wet" and "damp" housing)

[15] Friedman, S. (1996). Theoretical bases for understanding drug users' organizations. *International Journal of Drug Policy*, *7*,(4), 212–219. Friedman, S. R., de Jong, W., & Des Jarlais, D. (1988). Problems and dynamics of organizing intravenous drug users for AIDS prevention. *Health Education Research*, *3*(1), 49-57. doi:10.1093/her/3.1.49; Friedman, S. R., Des Jarlais, D. C., Soptheran, J. L., Garber, J., Cohen, H., & Smith, D. (1987). AIDS and self-organization among intravenous drug users. *International Journal of the Addictions*, *22*, 201-219. doi:10.3109/10826088709027425.

- Voluntary linkage of active drug users to medical, psychiatric, legal services
- Smoking cessation support, including nicotine replacement pharmacotherapies.

Theoretically, HR's programmatic services are focused on supporting the health of all people who choose to use alcohol and other drugs, not just those with severe AOD problems. In reality, HR programs often serve the most marginalized drug users—persons with histories of severe drug dependencies, co-occurring medical/psychiatric illnesses, poverty, educational deficits, chronic unemployment, homelessness or unstable living arrangements, and limited social resources.[16] Of particular note is the fact that HR programs serve individuals who do not seek addiction treatment and persons who are often not warmly welcomed by addiction treatment programs because of their history of multiple treatment admissions.

Several factors distinguish HR programs from traditional addiction treatment and recovery support programs, including:

- minimal if any service eligibility or service fee requirements,
- multiple points of service entry (versus a centralized intake),
- service delivery within the locations where clients live and use drugs,
- service goals set by each client rather than the program; abstinence not a requirement for service entry or retention,
- broad service menu encompassing numerous areas of life functioning,
- less hierarchical service relationships than in traditional professional service settings,
- the option of anonymity in service participation, and
- service duration (beginning and end) defined by the service consumer not the program or external funding/regulatory authorities.[17]

Harm Reduction and Abstinence-based Addiction Treatment/Recovery

AATR critics contend that HR programs 1) divert funds that could be used to expand abstinence-based treatment, 2) prolong drug use/addiction careers, 3) encourage new drug users via a message of drug tolerance, and 4) are a "Trojan horse" masking the goal of drug legalization.[18] HR advocates counter by arguing that:

- HR programs serve those individuals not served by the current treatment system and those who have not achieved abstinence through that system of care,
- there is no definitive scientific evidence that HR services prolong addiction careers[19] (only two studies of MMT were identified by the authors suggesting that

[16] Rogers, S. J., & Ruefli, T. (2004). Does harm reduction programming made a difference in the lives of highly marginalized, at-risk drug users? *Harm Reduction Journal*, *1*, 7. doi:10.1186/1477-7517-1-7

[17] Rogers, S. J., & Ruefli, T. (2004). Does harm reduction programming made a difference in the lives of highly marginalized, at-risk drug users? *Harm Reduction Journal*, *1*, 7. doi:10.1186/1477-7517-1-7

[18] Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from http://www.forward-thinking-on-drugs.org/review2-print.html

[19] Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from http://www.forward-thinking-on-drugs.org/review2-print.html

MMT either prolongs the duration of drug injecting[20] or reduces mortality while exerting no effect on such duration[21]),

- local HR services increase the prevalence of drug use,[22] and that
- the degree to which HR advocates support, oppose, or are neutral on the question of drug legalization varies across communities and countries.[23]

HR advocates have been equally critical of AATR programs, arguing that traditional AATR professional/peer programs: 1) do not voluntarily attract the majority of people with severe AOD problems, 2) use methods (e.g., confrontation techniques) that are disrespectful and harmful, 3) refuse to admit patients who are on medications (e.g., methadone, buprenorphine, psychotropics) for psychosocial support services, 4) refuse to acknowledge recovery status of medication-stabilized patients (e.g., denial of clean time, denial of opportunities for participation and leadership), 5) kick people out of treatment and/or deny readmission for becoming symptomatic (e.g., drug use), 6) infantilize and over-control people, 7) define any post-treatment drug use by a patient as a "failed" treatment, 8) blame patients for failed addiction treatment outcomes, and 9) are a modern throwback to religious and temperance movements.[24] AATR advocates counter that HR advocates have little understanding of addiction and what is required to successfully transition someone from addiction to long-term stable recovery.

Summarizing the stances of AATR and HR advocates and critics is challenged by the fact that AATR and HR are not homogenous movements.

Both AATR and HR advocates can suffer conceptual and practice blind spots. HR's focus on immediate needs and realistically achievable goals in the present can blind HR advocates to the potential for short- and long-term transformative change. AATR's focus on the vision of long-term stable recovery can blind them to the immediate needs of those who will not or cannot presently cease all drug use. Both AATR and HR advocates have been criticized for focusing almost exclusively on the individual and not on broader social contexts in which addiction flourishes or in which resilience and recovery flourish.[25]

Polemics between many AATR and HR advocates are giving way to more reasoned exchanges. The past decade has witnessed a softening of attitudes toward HR

---

[20] Maddux, J.F. & Desmond, D.P. (1992). Ten-year follow-up after admission to methadone maintenance. *American Journal of Drug and Alcohol Abuse*, *18*(3), 289-303.

[21] Kimber, J., Copeland, L., Hickamn, M., Macleod, J., McKenzie, J., De Angelis, D. & Roberston (2010). Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. *BMJ*,341, c3172. Accessed August 13, 2013 at http://dx.doi.org/10.1136/bmj..c3172.

[22] Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from http://www.forward-thinking-on-drugs.org/review2-print.html; Paone, D., Des Jarlais, D. C., Gangloff, R., Milliken, J., & Friedman, S. R. (1995). Syringe exchange: HIV prevention, key findings, and future directions. *International Journal of the Addictions*, *30*, 1647-1683. doi:10.3109/10826089509104419; Watters, J. K., Estilo, M. J., Clark, G. L., & Lorvick, J. (1994). Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *Journal of the American Medical Association*, *271*, 115-120.

[23] Hunt, N. (2003). A review of the evidence-base for harm reduction approaches to drug use. Retrieved March 23, 2013 from http://www.forward-thinking-on-drugs.org/review2-print.html

[24] Gleghorn, A., Rosenbaum, M., & Garcia, B. A. (2001). Bridging the gap in San Fracnisco: The process of integrating harm reduction and traditional substance abuse services. *Journal of Psychoactive Drugs*, *33*(1), 1-7. doi:10.1080/02791072.2001.10400461

[25] McKeganey, N. (2006). The lure and the loss of harm reduction in UK drug policy and practice. *Addiction Research & Theory*, *14*, 557-588. doi:10.1080/16066350601002369; White, W. L., Evans, A. C., & Lamb, R. (2010). *Community recovery*. Posted at www.williamwhitepapers.com and www.facesandvoicesofrecovery.com

by addiction professionals in the United States,[26] including those working within 12-Step-oriented treatment programs.[27] This shift is particularly noteworthy among addiction professionals working in settings such as outpatient programs, DUI/DWI programs, or private practices who address less severe AOD problems than those seen in detoxification or inpatient rehabilitation settings.[28] Experiments in integrating HR and AATR are proceeding internationally at both conceptual and practice levels.[29]

As the concepts of HR and recovery continue to become more nuanced through the processes of debate, accumulated experience, and scientific evaluation, efforts are increasing to integrate harm reduction efforts into mainstream addiction treatment and recovery support services.[30] Advocacy of such integration is bi-directional, with notable attempts to increase the HR orientation of addiction treatment and mutual aid programs[31] and parallel efforts to increase the recovery orientation of HR programs.[32]

There is growing consensus that working to reduce harm from current drug use is not incompatible with the goals of encouraging and supporting long-term recovery and

---

[26] McLellan, A. T. (2003). What's the harm in discussing harm reduction: An introduction to a three-paper series. *Journal of Substance Abuse Treatment, 25*, 239-240. doi:10.1016/S0740-5472(03)00084-9; Davis, A., & Rosenberg, H. (2012). Acceptance of non-abstinence goals by addiction professionals in the United States. *Psychology of Addictive Behaviors*. Advance online publication. doi:10.1037/a0030563.

[27] Goddard, P. (2003). Changing attitudes towards harm reduction among treatment professionals. A Report from the American Midwest. *International Journal of Drug Policy*, *14*, 257-260. doi:10.1016/S0955-3959(03)00075-6

[28] Davis, A., & Rosenberg, H. (2012). Acceptance of non-abstinence goals by addiction professionals in the United States. *Psychology of Addictive Behaviors*. Advance online publication. doi:10.1037/a0030563.

[29] Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs*, *33*(1), 23-26. doi:10.1080/02791072.2001.10400464; Futterman. R., Lorente, M., & Silverman, S. (2004). Integrating harm reduction in abstinence-based substance abuse treatment in the public sector. *Substance Abuse*, *25*(1), 3-7. doi:10.1300/J465v25n01_02; Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell. Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment*, *25*, 241-247. doi:10.1016/S0740-5472(03)00068-0; Mancini, M. A., Hardiman, E. R., & Eversman, M. H. (2008). A review of the compatibility of harm reduction and recovery-oriented best practices for dual disorders. *Best Practices in Mental Health*, *42*(2), 99-113. Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*(1), 13-21. doi:10.1080/02791072.2001.10400463; Ronel, N., Gueta, K., Abramsohn, Y., Caspi, N., & Adelson, M. (2010). Can a 12-step program work in methadone maintenance treatment? *International Journal of Offender Therapy and Comparative Criminology*, *55*(7), 1135-1153. doi:10.1177/0306624X10382570; Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guydish, J., Masson, C. L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence***,** *100*(1–2), 100–106. doi:10.1016/j.drugalcdep.2008.09.009; Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment*, *25*, 249-256. doi:10.1016/S0740-5472(03)00085-0; Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use, 18*, 56-64. doi:10.3109/14659891.2013.761024

[30] Gleghorn, A., Rosenbaum, M., & Garcia, B. A. (2001). Bridging the gap in San Fracnisco: The process of integrating harm reduction and traditional substance abuse services. *Journal of Psychoactive Drugs*, *33*(1), 1-7. doi:10.1080/02791072.2001.10400461; Lee, H. S., Engstrom, M., & Peterson, S. R. (2011). Harm reduction and 12 steps: Complementary, oppositional, or something in-between? *Substance Use and Misuse*, *46*, 1151-1161. doi:10.3109/10826084.2010.548435; Greenberg, B., Hall, D. H., & Sorensen, J. I. (2007). Methadone maintenance therapy in residential therapeutic community settings: Challenges and promise. *Journal of Psychoactive Drugs*, *39*, 203-210. doi:10.1080/02791072.2007.10400606; Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guydish, J., Masson, C. L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence***,** *100*(1–2), 100–106. doi:10.1016/j.drugalcdep.2008.09.009; Zweben, J. E., Aly, T., Martin, J., Wengrofsky, S., Bacci, J., & Meddaugh, R. (1999). Making residential treatment available to methadone patients. *Journal of Substance Abuse Treatment*, *17*(3), 249-256. doi:10.1016/S0740-5472(98)00073-7

[31] Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment*, *25*, 241-247. doi:10.1016/S0740-5472(03)00068-0; Klaw, E., Horst, D., & Humphreys, K. (2006). Inquirers, triers, and buyers of an alcohol harm reduction self-help organization. *Addiction Research and Theory, 14*, 527-535. doi:10.1080/16066350500537580; Kosok, A. (2006). The Moderation Management programme in 2004: What type of drinker seeks controlled drinking? *International Journal of Drug Policy*, *17*(4), 295-303. doi:10.1016/j.drugpo.2006.03.003

[32] White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, *11*(6), 44-53. Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use, 18*, 56-64. doi:10.3109/14659891.2013.761024

global health,[33] and there are growing points of intersection between AATR and HR programs, e.g., low threshold engagement strategies, person-centered and strengths-based assessment and service planning, peer-based support services, growing emphasis on continuity of contact and support over time.[34] HR and AATR also rest on a shared understanding that change is a process often involving incremental steps toward full problem resolution.[35]

In spite of such points of convergence, managing the ambiguities of integrating AATR and HR concepts and practices at the service practitioner or volunteer level can be quite difficult.[36]

AATR and HR in the City of Philadelphia

The City of Philadelphia has played a critical role in the history of abstinence-based treatment and recovery in the United States. Dr. Benjamin Rush's early conceptualization of chronic drunkenness as a disease and his call for specialized institutions for its treatment were released from Philadelphia in the late eighteenth and early nineteenth centuries. Some of America's earliest detoxification institutions (Burn Brae, 1859), inebriate asylums (Pennsylvania Sanitarium, 1867), inebriate homes (Franklin Reformatory Home for Inebriates, 1872), recovery mutual aid societies (Godwin Association, 1872), and other recovery support institutions (Workingman's Central Coffeehouse, 1874) as well as private addiction cure institutes (Keeley Institute, 1895) were located in Philadelphia and surrounding communities.[37]

Those early contributions continued with the research on opiate addiction conducted by Arthur B. Light and Edward G. Torrance at Philadelphia General Hospital under the auspices of the Philadelphia Committee for Clinical Study of Opium Addiction (1926-1928), the mid-century collaborations between Philadelphia hospitals and Alcoholics Anonymous, and the country's first (1935) integration of a recovering lay alcoholism therapist (Francis Chambers) within a multidisciplinary approach to the psychiatric treatment of alcoholism led by Dr. Edward Strecker at the Institute of the Pennsylvania Hospital. The Philadelphia area played key roles in the pre-modern era of addiction treatment and recovery in the United States and played a similarly prominent role in the rise of modern addiction treatment, including the early history of therapeutic communities[38] and the early integration of alcoholism and drug addiction treatment at Eagleville Hospital.

HR programs also have a distinguished history in Philadelphia. Consortium Inc.'s Drug Abuse Rehabilitation Program and Philadelphia General Hospital each began

---

[33] Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use, 18*, 56-64. doi:10.3109/14659891.2013.761024

[34] Mancini, M. A., Hardiman, E. R., & Eversman, M. H. (2008). A review of the compatibility of harm reduction and recovery-oriented best practices for dual disorders. *Best Practices in Mental Health*, *42*(2), 99-113. White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43. White, W. (2009). *The recovery paradigm and the future of medication-assisted treatment*. Plenary address to the American Association for the Treatment of Opioid Dependence, April 28, 2009. Posted at www.facesandvoicesofrecovery.org

[35] Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell.

[36] Koutroulis, G. (2000). "That original tension": Negotiating abstinence in clinicians' accounts of harm reduction in nonresidential treatment of heroin withdrawal. *Journal of Substance Abuse Treatment*, *19*, 89-98. doi:10.1016/S0740-5472(99)00087-2

[37] Leonard, E.C. (1997). The treatment of Philadelphia inebriates. *American Journal on Addictions*, 6, 1-10.

[38] Gaudenzia, 1968; White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

dispensing methadone in 1968. Dr. Bill Wieland, an early pioneer in these efforts, became the first medical director of Philadelphia's Coordinating Office of Drug and Alcohol Programs. Dr. Wieland, Dr. Jacob Schut, and Dr. Richard Cohen oversaw the early expansion of methadone maintenance treatment in Philadelphia. Medication-assisted treatment for addicted pregnant women in Philadelphia was pioneered during this early period by Dr. Loretta Finnegan. The growing network of MMT clinics took on a great HR orientation in response to the AIDS epidemic in the 1980s, and syringe and needle exchange services were introduced by PreventionPoint Philadelphia in 1991.

In the earliest years of their co-existence, AATR and HR programs in Philadelphia existed in isolation from one another, and their relationship, if it could even be called that, was marked by one of mutual suspicion, conflict, and competition for public support and resources. The context for bridging this ideological chasm was a recovery-focused behavioral health systems transformation process initiated in Philadelphia in 2005.[39] Roland Lamb, Director, Office of Addiction Services, Philadelphia Department of Behavioral Health Intellectual disAbility Services, explains:

> *There were times when an expansive ideological chasm existed between harm reduction organizations and most of our addiction treatment and recovery support organizations. Today, we are bridging that chasm through processes of mutual education and collaboration as we bridge public health and clinical models of intervention. Our traditional harm reduction organizations have moved from a position of isolation to become more integrated into the larger system of care in Philadelphia. They have also become more recovery-focused, with two of the earliest of such organizations—Action AIDS and the Mazzoni Center—now having treatment licenses. At the same time, many of our traditional drug-free treatment programs are incorporating harm reduction principles and practices. The shared vision emerging from our systems transformation process has been that of long-term health and wellness as incremental and continual processes at individual, family, and community levels."*[40]

This systems transformation process set the stage for increased communication and then collaboration between AATR programs, HR programs, and other community service entities. In the next section, we will outline four key programmatic areas where AATR and HR principles and practices were integrated, after which we will outline some of the key ideas and lessons that have emerged from these integration experiments.

HR and AATR Integration Profiles

---

[39] Achara-Abrahams, I., Evans, A. C., & King, J. K. (2011). Recovery-focused behavioral health systems transformation: A framework for change and lessons learned from Philadelphia. In J. F. Kelly & W. L. White (Eds.), *Addiction recovery management: Theory, science and practice* (pp. 187-208). New York: Springer Science. Evans, A. C. (2007). The recovery-focused transformation of an urban behavioral health care system: An interview with Arthur Evans, PhD. In W. L. White, *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright)*. Chicago, IL: Great Lakes Addiction Technology Transfer Center. Lamb, R., Evans, A. C., & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience. Posted www.facesandvoicesofrecovery.org

[40] Roland Lamb, personal communication, March 21, 2013

Assertive Outreach and Low-threshold Service Access Points. One of the Philadelphia systems transformation goals is to expand low threshold access points for those persons with behavioral health disorders who are at greatest risk for harm to themselves and others. A key mechanism for achieving this has been encouragement of traditional treatment providers to expand outreach and engagement services and by funding (via federal Access to Recovery funds) non-traditional service organizations (e.g., PreventionPoint, New Pathways, One Day at a Time, and the Recovery Community Center) to provide outreach and drop-in access points.

Public Health Management Corporation (PHMC) operates four programs that have an integrated HR and recovery orientation: New Pathways, New Pathways for Women, the HIV/HCV Prevention Street Outreach Project, and the Philadelphia Hepatitis Outreach Project. Between July 2012 and March 2013, these four programs collectively:

- logged more than 21,391 street encounters (engagement, information sharing, support, referral) by their respective outreach teams (see Figure One),
- hosted more than 7,615 drop-in center visits,
- conducted 278 HCV screenings and 216 HIV onsite rapid tests,
- linked 73 people to addiction treatment,
- hosted 2,728 visits for recovery support group meetings, and
- linked more than 1,620 individuals to other health and social service resources.[41]

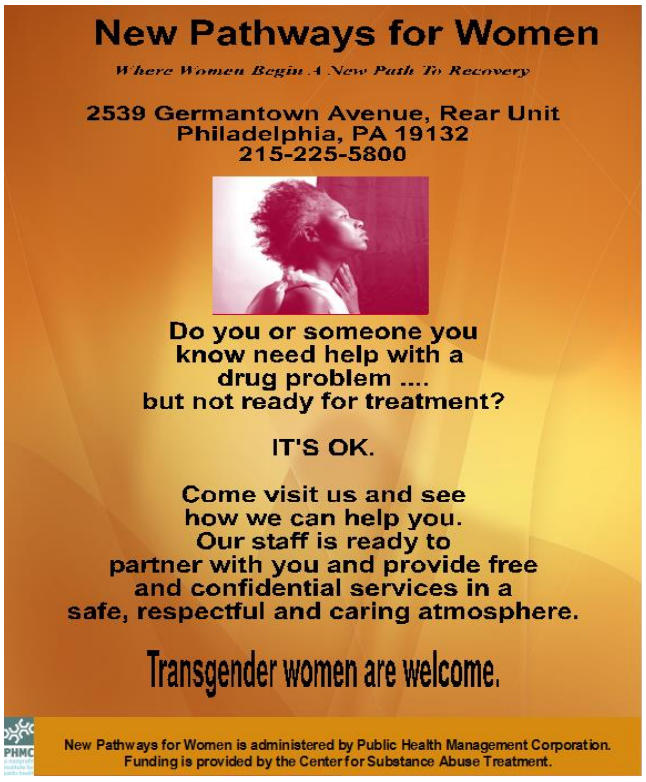


Figure One: New Pathways for Women Street Outreach Recruitment Flyer

[41] Eugenia Argires, personal communication, April 15, 2013

Eugenia Argires, Program Director at New Pathways (a program of the Public Health Management Corporation, PHMC), explains how HR and recovery perspectives have been integrated:

> *We reframe harm reduction within an expanded purpose of health promotion rather than an end in itself. This occurs with a trauma-informed perspective that recognizes the impact that violence and victimization may have on individuals' capacity to minimize harm associated with their substance use while partnering with them to strengthen their capacity to initiate and maintain their recovery. Harm minimization can be viewed as an end in itself or as a first step towards recovery. At New Pathways, we view it as the latter. We engage persons active in their addiction in a relational model that supports self-determined, incremental steps towards full recovery. For us, minimizing immediate harm is about helping people move towards hope, healing and health over the long term as they themselves define it. We do that through our community-based assertive street outreach programs focused on serving homeless individuals, and those with chronic substance use problems, the integration of behavioral health with primary care in our service linkages for persons with HIV/AIDS or viral hepatitis among other conditions, and our two neighborhood-based drop-in centers, one for women only. These programs provide welcoming spaces where even the smallest steps toward recovery are supported and celebrated. These types of pre-recovery (recovery priming) support services began in 1999 and have been progressively enhanced and expanded since that time. To us, recovery is best initiated and maintained in the support of your peers. Our pre-recovery support programs are a means of reaching people and welcoming them into this community of recovering people*.[42]

The core values and central beliefs guiding the low threshold support services provided by New Pathways is illustrated in the following messages conveyed to each service recipient:

- *We practice an intentional hospitality and will be a powerful antidote to the brutality of the streets. We meet all who enter our offices with a gentle warm welcome and a drink of water or other beverage, access to a restroom, and a comfortable seat in a beautiful, clean and colorful environment. We will keep your waiting time to meet with us as short as possible.*
- *We believe that anyone can recover, and that recovery is often an incremental process that can be effectively managed over time. We will support abstinence as your ultimate goal, but we understand your recovery is beginning if your use of drugs decreases. We will celebrate every success and provide you with support to continue forward with hope.*

[42] Eugenia Argires, personal communication, March 11, 2013

- *We believe there are many paths to recovery. Your path may be spiritual, clinical, cultural or peer-based. We will work with you to clear your path as you walk it.*
- *We are a trauma-informed recovery support program. We recognize that many individuals' lives have unfolded within violence and victimization, that their use of substances was their way to manage the distress of that violence and victimization, and that their continued use of substances puts them at further risk for more violence and victimization. We will never ask, "What is wrong with you?" but rather "What happened to you?" We will support you as you make the connections between your drug use and the losses you have suffered. We will partner with you as you explore the impact those losses have had on your life.*
- *We will help you if you ask us. Your participation in our projects will always be your choice and will only happen with your informed consent. We will proceed as your partner, at your pace.*
- *We will work hard to remove barriers to your recovery. You will not be mandated to enroll in our project as part of your parole requirement, or to maintain your housing, or to retain custody of your children, or to defer incarceration, or by any requirement other than a desire for recovery. We will support your recovery efforts because we believe you are entitled to receive our services and our help.*
- *We understand recovery is most consistently maintained in community, among the support of your peers. We believe that you will draw strength, resilience, and wisdom from each other.*[43]

Assertive outreach and engagement within a healing community is aimed at creating continuing, empathic relationships with active drug users that over time exert risk-reducing and recovery seeking influences.

Recovery-oriented Methadone Maintenance. Methadone maintenance was developed as a treatment for chronic heroin addiction by Drs. Dole, Nyswander, and Kreek in New York City in the mid-1960s and subsequently replicated throughout the U.S. and internationally.[44] A series of scientific reviews confirmed that methadone maintenance treatment (MMT) delivered at sustained optimal daily dosages by competent practitioners combined with ancillary psychosocial services:

1) decreases the death rate of opioid-dependent individuals by as much as 50%;
2) reduces the transmission of HIV, Hepatitis B and C, and other infections;
3) eliminates or reduces illicit opioid use;
4) reduces criminal activity;
5) enhances productive behavior via employment and academic/vocational functioning;
6) improves global health and social functioning; and

[43] Argires, E. (2013). *FINAL REPORT New Pathways for Women: Submitted to the Center for Substance Abuse Treatment Targeted Capacity Expansion for Substance Abuse Treatment and HIV/AIDS Services Grants TCE/HIV and Outreach*. Philadelphia, PA: Public Health Management Corporation.

[44] White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

7) is cost-effective.[45] (Evidence for 1, 2, 3, 4 & 7 is particularly strong; evidence for 5 and 6 is present but weaker.)

During the national and international diffusion of MMT, the emphasis within policy and clinical rationales for MMT shifted from a person-centered enhancement of global health and social functioning to an emphasis on reduction in personal and social harm—a shift that was profoundly influenced by concerns about addiction-related crime and the worldwide AIDS epidemic.[46] MMT can thus be designed as a primarily HR intervention or as a recovery-focused medical treatment for addiction. The former is focused primarily on what is reduced or removed from the life of service recipients (illicit opioid use, criminal activity, risk of HIV/AIDS and other infections) that poses risk of harm to oneself or the community. The latter includes but moves beyond HR to focus on what can be added to the life of service recipients (stable abstinence from alcohol and non-prescribed drugs, enhanced global—physical, emotional, relational, spiritual—health, and enhanced citizenship (community integration and community service).[47]

MMT has been provided in Philadelphia as a treatment for opioid addiction since 1967. Today (2013), between 4,600 and 5,000 MMT patients are enrolled on any given day within Philadelphia's 13 DBHIDS-funded opioid treatment programs (11 organizational providers). The MMT-related goals within Philadelphia's behavioral health systems transformation process were to enhance professional, recovery community, and public understanding of the rationale and scientific evidence supporting MMT while at the same time elevating the quality of MMT in areas critical to enhancing long-term recovery outcomes. More specifically, efforts were made to enhance access to MMT, eliminate arbitrary limits on the duration of MMT, ensure safe induction and individually optimal dosages of medication, enhance retention in MMT, and amplify psychosocial supports and ancillary services during and following MMT. A clear nexus exists between each of these goals and enhanced prognosis for long-term recovery.[48]

The systems-level mechanisms for achieving these goals have included:

- using the Medication-assisted Treatment Providers (MATP) group as a forum for enhanced HR and recovery-focused transformation of MMT,

---

[45] Ducker, E., Lurie, P., Wodakt, A., & Alcabes, P. (1998). Measuring harm reduction: The effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. *AIDS, 12*(suppl A), S217-S230. Institute of Medicine (1990). *Treating drug problems, Vol. 1*. Washington, DC: National Academy Press. Kreek, M. J., & Vocci, F. (2002). History and current status of opioid maintenance treatments. *Journal of Substance Abuse Treatment, 23*(2), 93-105. doi:10.1016/S0740-5472(02)00259-3; Mattick R.P., Breen, C., Kimber, J., & Davoli, M. (2003). Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews, (Issue* 2):CD002209. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. *Journal of the American Medical Association, 280*(22), 1936-1943. doi:10.1001/jama.280.22.1936; U.S. General Accounting Office. (1990). *Methadone maintenance: Some treatment programs are not effective; greater federal oversight needed* (GAO Report No. GAO/HRD-90-104). General Accounting Office.

[46] Clark, C. (2012). "Chemistry is the new hope": Therapeutic communities and methadone maintenance, 1965-71. *Social History of Alcohol and Drugs, 26*(2), 192-216. White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor, 11*(6), 44-53.

[47] White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor, 11*(6), 44-53.

[48] White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor, 11*(6), 44-53.

- developing and widely disseminating the monograph, *Recovery-oriented Methadone Maintenance*,[49]
- discussing how to improve clinical responses to continued drug use by MMT patients—including development of guidelines on the management of benzodiazepines in medication-assisted treatment,
- developing an MATP plan to address stigma related to medication-assisted treatment and publishing/posting a series of stigma-related papers,[50]
- asserting a definition of recovery that embraces stabilized MMT patients who abstain from alcohol and non-prescribed drug use within the sobriety element of the emerging consensus definitions of recovery,[51]
- enhancing rates to lower MMT counselor-patient ratios, increase case management and psychiatric services, encourage peer support services, and expand use of recovery plans,
- encouraging development of MMT consumer councils or patient advisory committees and including MMT patients in policy discussions and local hearings related to MAT,
- reducing barriers for admission (co-enrollment) of MMT patients into other services and encouraging bi-directional referrals between MAT and other service modalities toward the goal of "No closed doors for MMT patients",
- supporting integration of medication into traditionally drug-free treatment programs (e.g., Eagleville Hospital),[52]
- ensuring that methadone is available across all levels of care within the system,
- ensuring access to methadone for incarcerated MAT patients and assertively linking incarcerated persons to clinics for recovery planning and community re-entry, and
- supporting PRO-ACT's (local recovery advocacy organization) development of a consumer's guide for medication-assisted addiction treatment.
- using community participatory art projects to increase understanding of addiction and MMT

---

[49] White, W. (2011b). Reflections on medication-assisted recovery. *Resource Links*, *10*(1), 6-7. Northeast Addiction Technology Transfer Center. White, W. (2012a). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases*, *31*(3), 199-206. doi:10.1080/10550887.2012.694597; White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com; White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, *11*(6), 44-53. White, W. & Mojer-Torres, L. (2011). Recovery-oriented Methadone Maintenance: A coming of age. *Addiction Treatment Forum*, *21*(1), 1, 5.

[50] White, W. (2009). *The recovery paradigm and the future of medication-assisted treatment*. Plenary address to the American Association for the Treatment of Opioid Dependence, April 28, 2009. Posted at www.facesandvoicesofrecovery.org; White, W. (2011b). Reflections on medication-assisted recovery. *Resource Links*, *10*(1), 6-7. Northeast Addiction Technology Transfer Center. White, W. (2012a). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives. *Journal of Addictive Diseases*, *31*(3), 199-206. doi:10.1080/10550887.2012.694597; White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com; White, W., Parrino, M., & Ginter, W. (2011). *A dialogue on the psychopharmacology in behavioral healthcare: The acceptance of medication-assisted treatment in addictions*. Briefing paper for SAMHSA's A Dialogue on Psychopharmacology in Behavioral Healthcare meeting, October 11-12, 2011. Posted at www.williamwhitepaers.com

[51] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. doi:10.1016/j.jsat.2007.06.001; White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241. doi:10.1016/j.jsat.2007.04.015

[52] Deal, D., Folks, C., & White, W. (2011). Methadone maintenance patients in a residential rehabilitation program: The Eagleville experience. Posted at www.williamwhitepapers.com

A forthcoming paper on the 10-year evaluation of Philadelphia's systems transformation will report the results of the measurable benchmarks being used to evaluate these efforts.

Needle and Syringe Exchange Programs (NSEP). NSEPs exchange sterile needles and syringes used for injections as a vehicle for reducing the transmission of infectious diseases and providing other harm reduction-related information and services. They are intended to promote individual and public health by reducing the length of time each potentially contaminated needle and syringe is in circulation, increasing the availability of sterile needles and syringes, and increasing the speed at which used needles/syringes are removed from the community environment.[53] NSEPs have been among the most controversial of HR services, with the U.S. banning use of federal funds for NSEPs and for a time even banning use of federal funds to evaluate the effectiveness of NSEPs.[54]

PreventionPoint Philadelphia (PPP), catalyzed by Philadelphia's chapter of ACT UP (AIDS Coalition to Unleash Power), began providing needle and syringe exchange services in 1991 at a time this activity was still illegal. PPP worked with Philadelphia Mayor Ed Rendell's office to issue a 1992 executive order declaring AIDS a public health emergency warranting legal expansion of syringe exchange operations. PPP's syringe exchange and other harm reduction initiatives have since been funded by the City's behavioral health and public health departments and through the support of private foundations.

PPP's service menu currently includes eight syringe exchange sites, a drop-in center, and a free medical clinic. Collectively, these sites provide syringe exchange, confidential HIV testing and counseling, Hepatitis C screening, opiate overdose prevention trainings with naloxone distribution, and referrals to drug treatment, medical care, legal services, case management, public assistance, and medical assistance. In FY 2011, PPP distributed more than 1.3 million syringes (94.9% exchange rate) in 14,845 exchange transactions to 3,894 individuals at its eight syringe exchange sites.[55]

PPP has served more than 15,000 individuals since its inception in 1991 and has worked in tandem with other organizations such as Project SAFE that works with female sex workers, some of whom are also injection drug users. Since PPP's inception, the percentage of injection drug users within new cases of HIV infection in Philadelphia has dropped from 50.5% of new cases in 1992 to 17.5% of new cases in 2007[56] while the cumulative representation of injection drug users within all cases dropped from 33.2% of prevalent cases in 1980-2007 to 10.2% of cases in 2010.[57] The estimated cost for each case of HIV infection averted through syringe exchange services in Philadelphia has been estimated to be between $2300-4200, compared to the estimated lifetime cost of HIV treatment of nearly one million dollars.[58]

---

[53] Ducker, E., Lurie, P., Wodakt, A., & Alcabes, P. (1998). Measuring harm reduction: The effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. *AIDS, 12*(suppl A), S217-S230.

[54] Strathdee, S. A., & Pollini, R. A. (2007). A 21st-century Lazarus: The role of safer injection sites in harm reduction and recovery. *Addiction, 102*, 848-849. doi:10.1111/j.1360-0443.2007.01859.x

[55] Prevention Point Philadelphia Reports provided by José Benitez, March 12, 2013

[56] Schwarz, D. F., Feyler, N., Cella, J., & Brady, K. A. (2008). *AIDS in Philadelphia: 2008 Report on HIV/AIDS Care and Prevention in the City of Philadelphia.*

[57] Shpaner, M., Brady, Kathleen, & Eberhart, M. (2010). *Surveillance Report 2010*. Program Manager. Philadelphia.

[58] Harris, Z. K. (2006). Efficient allocation of resources to prevent HIV infection among injection drug users: The Prevention Point Philadelphia (PPP) needle exchange program. *Health Economics*, *15*(2), 147–58. doi:10.1002/hec.1021

José Benitez describes the role of choice in the PreventionPoint philosophy.

> *We are creating a buffet of service and support choices. Even within PreventionPoint Philadelphia, we have people who bring a diversity of past experiences and orientations to our work. That diversity itself is part of the buffet. Flexibility and openness to multiple pathways and styles of moving toward healing and wellness are part of our organizational DNA.*[59]

Stephen Bamber from the UK has described how NSEPs may integrate increased recovery orientation into a more traditional HR perspective.

> *A recovery focused NSP will be driven by a vision that creates a therapeutic space conducive not only to safer injection practices, but also to actively promoting and supporting engagement for long-term recovery from problematic substance use. Ideally, this means making visible recovery successes and articulating a robust, realistic narrative of recovery that is meaningful and appropriate to the injecting population. …if there is an authentic, realistic possibility of recovery, then there is arguably an ethical imperative to promote and provide access to services that deliver recovery-oriented change….The Journey towards a full and meaningful life that is recovery can begin in the most unlikely of places. Why not through the doors of a needle exchange programme?*[60]

While there are anecdotal accounts of people finding recovery through contact with NSEP staff and volunteers and NSEP studies evaluating effects of NSEPs on mortality and health, the authors know of no study to date that has investigated recovery outcomes of NSEP participants. The dichotomous worlds of harm reduction and recovery have precluded examination of this type of outcome.

Housing Support Continuum. Housing support is a critical issue for homeless persons/families affected by substance use disorders and related medical and psychiatric disorders, with many such individuals/families living on the streets or using shelters, jails, hospitals, and various treatment facilities for temporary shelter. The most recent (Winter 2013) point-in-time count of homeless persons in Philadelphia revealed 388 homeless individuals within the street; 127 individuals at St. John's Coffeehouse, Navigation Center, or Bethesda Café; and 1,172 individuals and 1,673 members of family units residing in Philadelphia's shelter services.[61]

A review of death data for Philadelphia's homeless population underscores the need for assertive outreach and engagement. Of homeless persons who died in 2009-2010, 74% had one or more chronic medical illnesses at the time of death, 63% had a history of excessive substance use (with 44% having substance intoxication as a primary or contributing cause of death), and 52% had a prior history of mental illness. Discovery

---

[59] José Benitez, March 12, 2013

[60] Bamber. S. (2010). The role of syringe and needle programmes in a recovery-oriented treatment system. *Recovery writing: Volume one, 2009-2010*, pp. 48-54. Retrieved February 12, 2013 from www.theartoflifeitself.org/publications/recovery_Writing_Volume_One.2009_2010.pdf

[61] Health & Opportunity, Quarterly Point in Time Homeless Count, Winter, 2013

that over one-third of homeless persons who died had been in contact with at least one community service agency in the 30 days prior to their death fueled the decision to expand assertive outreach, housing supports, low threshold behavioral health treatment services, and allied health services.[62]

"Housing First" is a term used to characterize programs that address homelessness by providing rapid access to housing that is not contingent upon broader changes in behavior, e.g., immediate entry into psychiatric or addiction treatment. The goal is to provide housing stability and offer a wide spectrum of ancillary services that promote health and social functioning without requiring either abstinence or continued service participation. Housing First was developed as an alternative to the more traditional approach of requiring treatment participation for entry into and maintenance of housing support toward the long-term goal of stable recovery and permanent housing. Housing First emerged due to problems attracting and retaining individuals experiencing homelessness within traditional service venues, particularly psychiatric treatment, as well as problems with post-treatment resumption of addiction, homelessness, and related problems.[63] Housing First programs have been able to achieve high rates of housing placement and high rates of housing retention without increasing AOD use and have been able to provide support services that enhance recovery readiness.[64]

Philadelphia has developed an array of supportive housing options to address the need for affordable and supportive housing for persons with and recovering from AOD-related problems, including those with co-occurring mental illness. Beginning in the late 1980s with the development of 1260 Housing Development Corporation, the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) partnered with Housing Funding sources and used county resources to increase access to housing supports. Since the early 1990s, Philadelphia DBHIDS has partnered with the McKinney Vento Continuum of Care (COC) to develop both project-based and scattered site supportive housing.

In 2003, Philadelphia began its first Housing First program, with Horizon House Inc. and 1260 Housing Development Corporation. In 2008, the city began a partnership with the Philadelphia Housing Authority for 200 set aside vouchers a year, to support the city's 10 Year Plan to End Homelessness. Using these and other housing resources, Philadelphia has been able to house 1,916 persons since 2007, including 1,461 individuals with a history of chronic homelessness and living on the streets. Housing options include programs with an AATR perspective, as well as programs that take an HR approach. Most "clean and sober" housing was developed from the early '90s to the early '00s, and most of the Housing First programs were developed after that. Many of these early programs primarily served individuals experiencing severe mental illness, e.g., New Keys (2003), Home First (2004), and Pathways to Housing (2008).

Pathways to Housing recently (2010) initiated the CHIPS program, a 10-bed Housing First project specifically designed to address chronic alcoholism. Pathways' Housing First initiative reported serving 22 individuals with chronic alcohol dependence, prolonged homelessness, and high rates of comorbid psychiatric and physical illnesses.

---

[62] City of Philadelphia Homeless Death Review, 2009-2010

[63] Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, *94*(4), 651-656.

[64] Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, *94*(4), 651-656.

Preliminary results include a high rate of stable housing (72%), improved rates of sobriety (from 1-20 months), and enhanced rates of engagement in addiction treatment and medical/psychiatric services.[65] Other Philadelphia-based low threshold programs that combine housing access with addiction and/or psychiatric treatment include six Journey of Hope Project (JHP) sites developed in collaboration between DBHIDS and the Office of Supportive Housing (2007-2008). A report on the JHP sites has been recently published.[66]

Collectively, these programs provide strategies of assertive outreach, warm welcome, and resistance management (motivational interviewing); a continuum of wet, damp, and dry housing; transitional, supported, and permanent housing; health screenings; evidence-based interventions (e.g., cognitive behavioral and contingency management strategies) modified for this population; intensive case management and assertive linkage to recovery community resources (e.g., recovery mutual aid meetings, recovery homes, recovery community center, recovery advocacy activities). In FY 2012, DBHIDS-funded street outreach and housing programs made 37,687 contacts with 5,570 individuals (unduplicated), placing 1,616 individuals in resources ranging from shelters, hospitals, detox programs, overnight cafes, recovery homes, boarding houses, and family or friends. 428 of these individuals were placed multiple times during FY 2012.[67]

The growing continuum of wet, damp, and dry housing poses challenges about how to personally match such services. Dr. Marcella Maguire, Director, DBHIDS Homeless Services, explains:

> *The question we face with this growing menu of services is how to improve our screening and assessment processes to assure the best possible match between person and program. We now have this broad continuum of housing services. The critical challenge we face is determining which services are best suited to help each individual reduce the threat of imminent harm to self and others while enhancing his or her chances for long-term recovery and community reintegration. For example, we serve people who are in the process of early disconnection from family and community and those with prolonged histories of such disconnection; we need better ways to differentiate how to best match services to these different populations.*[68]

Supporting traditional abstinence-based programs to integrate HR principles to address the conjoined problems of addiction and homelessness has not been easy.

> *Supporting programs that have a strong abstinence orientation in their DNA to broaden their perspective to include support for people in pre-recovery stages of change is difficult but we are finding areas of common ground between these two perspectives. Most of the deaths of homeless people in Philadelphia are a direct*

[65] Dichter, H., Fussaro, A., Weinsteion, L., Tynanon, R., & Ellington, K. (2013). *Outcome evaluation for Pathway's Chronic Inebriate Program.* Submitted to DBHIDS February 11, 2013.

[66] Maguire, M, Sheahan, T. M., & White, W. L. (2011). *"I wanted a new beginning"* Innovations in recovery management for people experiencing prolonged homelessness in the City of Philadelphia. *Alcoholism Treatment Quarterly, 30,* 3-21. doi:10.1080/07347324.2012.635548; personal communication with Marcella Maguire and Timothy Sheahan, April 9, 2013

[67] Marcella Maguire, personal communication, April 9, 2013

[68] Personal communication, Marcella Maguire, April 9, 2013

result of alcohol and drugs. The treatment system has a responsibility to reach this population at highest risk of addiction-related death.[69]

Cross-initiative Themes. There are several connecting themes within the four areas of HR and AATR integration we have profiled. By blending HR and recovery support, Philadelphia is:

- identifying and engaging people at earlier stages of AOD problem development,
- identifying and (re)engaging people in the latest stages of addiction who have resisted treatment involvement or who have been repeatedly recycled through brief episodes of acute stabilization via medical treatment, detoxification, or addiction treatment,
- lowering access barriers to stable housing, addiction treatment, and related health and social services for those in greatest need, e.g., warm welcome and open readmission policies,
- streamlining assessment and intake procedures (e.g., registration in less than a minute at PPP syringe exchange sites),
- altering administrative discharge policies that in the past have kicked people out of treatment for confirming their diagnosis,
- enhancing linkages between HR and AATR resources, e.g., placement of DBHIDS staff person within PreventionPoint to facilitate direct and rapid entry into the treatment system and a pilot project to link needle exchange clients to suboxone treatment,
- shifting from short-term fixed lengths of stay to open-ended lengths of stay in housing programs,
- ensuring continuous and integrated care across multiple levels of care, and
- elevating the visibility of recovery role models (living proof) and peer support at all points of service contact.

Roland Lamb, Director of the Office of Addiction Services, describes the philosophy behind low threshold services that integrate HR and AATR:

Recovery has within it an implicit and explicit goal of reducing harm. Stable recovery is the ultimate harm reduction strategy. Our mantra is "no closed doorways to recovery." We will meet people where they are on any day and support on that day even the smallest steps towards recovery and wellness that the individual is willing to take, all the while affirming their potential for full recovery and our willingness to walk this path with them.[70]

Such low threshold services are garnering considerable scientific support as well. For example, reviews of studies of assertive community-based outreach programs aimed at injection drug users have shown positive outcomes related to reduction/cessation of injection drug use, reduction/cessation of reuse and sharing of injection equipment, reduction/cessation of other drug use (e.g., crack cocaine), increased use of condoms, and

[69] Personal Communication, Marcella Maguire, April 9, 2013
[70] Roland Lamb, Personal Communication, March 21, 2013

increased treatment entry.[71] Such outcomes can reduce harm to multiple parties while simultaneously enhancing recovery prospects and reducing multiple burdens of illness potentially brought into a long-term recovery process.

Dr. Arthur Evans, Jr., DBHIDS Commissioner, explains how HR and AATR perspectives are integrated within these low threshold services.

> *Traditional harm reduction programs have pioneered low threshold services, but they have often also been characterized by low expectations. Our vision is to expand low threshold services that at the same time elevate peoples' sense of what is possible for them. We do this by exposing them to living proof that recovery is possible even under the most difficult of circumstances, confirming that there are people who will walk this path with them, and offering stage-appropriate services to support people in their journeys from addiction to recovery*.[72]

One of the lessons we are learning in this process is how to stay engaged with people who at one point may not be interested in embarking on this recovery journey who, through repeated encounters with people in recovery, may be so interested at a later point in time.

Key Understandings about the Course and Consequences of AOD Use and Related Problems and Their Resolution Process

In the remainder of this article, we will explore some of the key understandings that can form a foundation for greater AATR/HR collaboration and integration. Many of these ideas have been influential within the recovery-focused transformation of the behavioral health care system in the City of Philadelphia.

AOD Use and Harm to Self and Others

HR-oriented services can preserve life during periods of active drug use and reduce the baggage (burdens) brought into a subsequent recovery process. Irreparable harm to individuals, families, and communities can occur as a result of AOD use—both from a single episode of use and from prolonged use. A major goal of HR is to prevent such irreparable harm.[73] For that population of people who will end up defining themselves as persons in recovery, HR serves to preserve life and the future option of recovery while reducing the harmful burdens and legacies of addiction brought into the recovery process, e.g., HIV/AIDS, viral hepatitis, and other potentially chronic and life-threatening health conditions; injury to others. Reductions in drug-related harm to self and others can be achieved for some individuals with or without their movement toward complete abstinence; however, sustained abstinence, when personally chosen and

[71] Coyle, S. L., Needle, R. H., & Normand, J. (1999). Outreach-based HIV prevention for injecting drug users: A review of published outcomes data. *Public Health*, *113*(Supplement 1), 19-30.
[72] Personal Communication, Dr. Arthur Evans, Jr. March 20, 2013
[73] IHRA, 2013 What is harm reduction. Accessed May 30, 2013 at http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf

achieved, remains the ultimate strategy for eliminating AOD-related harm to self and others.[74]

Both AATR and HR programs have the responsibility of enhancing coping methods and increasing social supports as AOD use decelerates or ceases. Such supports are critical to prevent inadvertent harm resulting from the service intervention. AOD use can be viewed as attempted acts of self-care (self-prescription)[75] that for some morph through neurobiological processes into drug addiction and compulsive acts of self-destruction.[76] In persons using alcohol and other drugs to self-medicate other conditions, particularly severe emotional distress and symptoms of severe psychiatric illness, abstinence or even deceleration of AOD use could result in harm if healthier alternatives for management of these conditions are not developed.[77] There is, for example, evidence of the potential for psychiatric deterioration during and following addiction treatment.[78] Further, a complex relationship exists between AOD use and the risk of aggression towards self and others, with AOD use potentially having inhibiting as well as promoting effects on such aggression.[79] Effective AATR and HR programs combine enhancement of alternative coping skills, social support, and reshaping norms and behavioral practices within community social networks.

AATR, HR, and Addiction/Recovery Careers

Integrated AATR and HR principles and practices provide a way to reach, engage, and support positive change across the arenas of drug use, addiction, and recovery. Addiction careers—measured from onset of AOD-related problems to the stable resolution of these problems either through abstinence or decelerated patterns of use—are for most individuals measured not in months or years but in decades.[80]

AATR and HR represent not opposing strategies but approaches to reaching different populations and reaching the same individuals at different stages of their AOD use, addiction, and recovery careers. Addiction careers become careers rather than brief developmental episodes primarily because of the combination of problem severity/complexity and the absence of personal, family, and community recovery capital (resources that can be mobilized to initiate and sustain long-term recovery). We need more nuanced, actionable models that deepen our understanding of AOD use and the

---

[74] Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 21*(6), 779-788. doi:10.1016/0306-4603(96)00042-1; Marlatt, G. A. (1998). *Harm reduction: Pragmatic strategies for managing high-risk behaviors*. New York: Guildford Press.

[75] Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs, 33*(1), 23-26. doi:10.1080/02791072.2001.10400464; Khantzian, E. J. (1989). Addiction: self-destruction or self-repair? *Journal of Substance Abuse Treatment, 6*(2), 75. doi:10.1016/0740-5472(89)90032-9; Khantzian, E .J. (1990). Self-regulation and self-medication factors in alcoholism and the addictions. Similarities and differences. *Recent Developments in Alcoholism, 8*, 255-271.

[76] Volkow, N., & Li, T-K. (2006). The neuroscience of addiction. *Nature, 8*(11), 1429-1430. Shaham, Y., & Hope, B. (2006). The role of neuroadaptations in relapse to drug seeking. *Nature, 8*(11), 1437-1439.

[77] Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high-risk behaviors*. Chichester: Wiley-Blackwell.

[78] Ilgen M. A., & Moos R. (2006). Exacerbation of psychiatric symptoms during substance use disorder treatment. *Psychiatric Services, 57*, 1758-1764. doi:10.1176/appi.ps.57.12.1758

[79] White, W. (2004). Substance use and violence: Understanding the nuances of the relationship. *Addiction Professional, 2*(1), 13-19.

[80] Hser, Y.-I., Anglin, M. D., Grella, C., Longshore, D., & Prendergast, M. L. (1997). Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment, 14*(6), 543-558. doi:10.1016/S0740-5472(97)00016-0; Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry, 58*(5), 503-508. doi:10.1001/archpsyc.58.5.503; Dennis, M. L., Scott, C. K., Funk, R., & Foss, M. A. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment, 28,* S51-S62. doi:10.1016/j.jsat.2004.10.013

onset, maintenance, and resolution of AOD problems within these longer developmental perspectives.

Addiction/Recovery in the Context of Multiple Disabling Conditions

Integrated AATR and HR principles and practices are particularly important for addressing multiple, severe, complex, and chronic (often intergenerational) problems. The most severe patterns of addiction are often marked by multiple problems that interact concurrently and sequentially to impede the resolution of any single problem in isolation from the larger cluster. Such problem multiplicity characterizes those who are in greatest need of HR, addiction treatment, and recovery support resources.

While HR and AATR are often portrayed as either/or options and that participation in HR programs may prevent participation in more mainstream service interventions, that is not the case in Philadelphia. Most of those involved in the most controversial of HR programs (from syringe exchange to methadone maintenance programs) in Philadelphia (and we assume other cities as well) present with complex service histories within mainstream organizations that have not resulted in sustainable recovery. The failure of traditional service programs with this population is to a great extent related to the issue of problem complexity: the interaction of severe (often intergenerational) patterns of addiction with co-occurring psychiatric illness, co-occurring medical illness (including presence or risk for HIV/AIDS and viral hepatitis), malnutrition, involvement in criminal justice and child protection systems, episodic or prolonged homelessness, isolation from or turbulence of family and intimate relationships, educational deficits, prolonged unemployment, and lack of financial capital.[81]

Most individuals participating in Philadelphia's HR programs are economically and socially marginalized, have already been involved in prior addiction treatment programs (94% in one recent study sample)[82] and other service programs, and report that they are not warmly welcomed within mainstream health and human service organizations because of the duration, severity, and complexity of their problems and their equally long and complex service histories. Addressing problems of these individuals and families requires service designs by AATR and HR programs that address these twin challenges of high problem severity, complexity, and chronicity and low recovery capital. To state that this population faces significant obstacles to change does not mean that positive incremental changes and even stable long-term recoveries are impossible. The question is how to incite and sustain such incremental steps in the change process on a community-wide level and have stage-focused benchmarks to evaluate individual progress and systems performance.

Changes in Drug Use during the Course of AOD Problems and the Stages of Resolution

Shifts in drug choice and changes in the frequency, methods of administration, and contexts for use can be viewed within an "all or none" view of addiction recovery or viewed as incremental movement towards problem resolution that constitute an

[81] This is the pattern presented by most persons using needle exchange services in Philadelphia, with as many as 80% of those using PreventionPoint's syringe exchange services either homeless or experiencing unstable/unsafe housing (José Benitez, personal communication, March 12, 2013).

[82] Kecojevic, A., Silva, K., Benitez, J., Gibble, E., & Lankenau, S. (2011). *Initial evaluation of overdose prevention program in Philadelphia*. Poster presented at the 2011 annual meeting of the American Public Health Association.

important "recovery priming" process that should be acknowledged and supported. Stepping stone patterns of drug use can involve patterns of accelerating (stepping up), decelerating patterns of risk related to patterns of drug use (stepping down), or cessation of use of all substances (stepping off).[83] While risks of multiple drug use and secondary drug dependencies are a concern within stepping down strategies, some individuals use a shift to an alternative drug choice as a permanent strategy or a transitional stage in their efforts to reduce harms related to their drug use or escape drug dependency.[84]

There are numerous reports of persons dependent upon opiates or alcohol achieving abstinence from these substances by using cannabis as a substitute,[85] including medical marijuana patients who use cannabis substitution as a strategy for resolving problems of alcohol and other drug dependencies.[86] While some addictionologists have even suggested the development of 12-step groups for those who only use cannabis as a support for abstinence from other drugs,[87]there is no evidence yet to support this strategy. The risks of this strategy must be viewed within the "hierarchy of harms" framework, the growing evidence of the potential for cannabis dependence,[88] and the lower rates of remission from cannabis dependence for individuals who fit the profile of those using HR services (e.g., lower income, lower education, high substance use severity, and co-occurring psychiatric illness).[89]

Similarly, illicit methadone or buprenorphine use may be used for self-medication for heroin withdrawal or self-administered detoxification from heroin, rather than for purposes of intoxication, and such use can be a prelude to entry into medication-assisted treatment.[90] Several recent studies have confirmed the use of illicit buprenorphine for purposes of self-medication of withdrawal symptoms or for self-treatment opioid addiction via progressive self-detoxification.[91] Persons involved in such patterns could

---

[83] Sifaneck, S. J. & Kaplan, C. D. (1995). Keeping off: stepping on and stepping off: The stepping stone theory reevaluated in the context of the Dutch cannabis experience. *Contemporary Drug Problems*, *22*(8), 483-512.

[84] Labigalini, E., Rodrigues, L. R., & Da Silveria, D. X. (1999). Therapeutic use of cannabis by crack addicts in Brazil. *Journal of Psychoactive Drugs*, *31*, 451-455. doi:10.1080/02791072.1999.10471776; Reiman, A. (2009). Cannabis as a substitute for alcohol and other drugs. *Harm Reduction Journal*, *6*, 35. doi:10.1186/1477-7517-6-35

[85] Best, D., Gossop, M., Greenwood, J., Marsden, J., Lehman, P. & Strang, J. (1999). Cannabis use in relation to illicit drug use and health problems among opiate misusers in treatment. *Drug and Alcohol Review*, 18, 31-38; Schiff, M., Levitt, S. & Moreno, R.C. (2007). Retention and illicit drug use among methadone patients in Israel: A gender comparison. *Addictive Behaviors*, 32, 2108-2119; Mikuriya, T. (2004). Cannabis as a substitute for alcohol: A harm reduction approach. *Journal of Cannabis Therapeutics*, *4*, 79-93. doi:10.1300/J175v04n01_04

[86] Reiman, A. (2009). Cannabis as a substitute for alcohol and other drugs. *Harm Reduction Journal*, *6*, 35. doi:10.1186/1477-7517-6-35

[87] Mikuriya, T. (2004). Cannabis as a substitute for alcohol: A harm reduction approach. *Journal of Cannabis Therapeutics*, *4*, 79-93. doi:10.1300/J175v04n01_04

[88] Hathway, A. D. (1997). Cannabis effects and dependency concerns in long-term frequent users: A missing piece of the public health puzzle. *Addiction Research & Theory*, *11*, 441-458. Hathaway, A. D, Callaghan, R. C., Macdonald, S., & Erickson, P. G. (2009). Cannabis dependence as a primary drug use-related problem: The case for harm reduction-oriented treatment options. *Substance Use and Misuse*, *44*, 990-1008. doi:10.1080/10826080802494875

[89] Flórez-Salamanca, L., Secades-Villa, R., Budney, A. J., García-Rodríguez, O., Wang, S., & Blanco, C. (2013). Probability and predictors of cannabis use disorders relapse: results of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Drug and Alcohol Dependence*. Advance online publication. doi:10.1016/j.drugalcdep.2013.01.013

[90] Gwin Mitchell, S. G., Kelly, S. M., Brown, B. S., Schacht Reisinger, H., Peterson, J. A., Ruhf, A.,…Schwartz, R. P. (2009). Uses of diverted methadone and buprenorphine by opioid-addicted individuals in Baltimore, Maryland. *The American Journal on Addictions*, *18*, 346-355.

[91] Bazazi, A. R., Yokell, M., Fu, J. J., Rich, J. D., & Zaller, N. D. (2011). Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *Journal of Addiction Medicine*, *5*(3), 175–80. doi:10.1097/ADM.0b013e3182034e31; Daniulaityte, R., Falck, R., & Carlson, R. G. (2012). Illicit use of buprenorphine in a community sample of young adult non-medical users of pharmaceutical opioids. *Drug and Alcohol Dependence*, *122*(3), 201–207. doi:10.1016/j.drugalcdep.2011.09.029; Yokell, M., & Zaller, N. (2011). Buprenorphine and buprenorphine/naloxone diversion, misuse, and illicit use: An international review. *Current Drug Abuse Reviews*, *39*(3), 236–247. doi:10.1016/j.jsat.2010.06.004.

be targeted for intense outreach and treatment engagement via the kind of low-threshold service programs described above.

Resistance and ambivalence are a natural—not pathological—response to internal and external pressure to change deeply engrained behaviors. Working through such resistance and ambivalence is an expected part of the process of incremental change. The 'tipping point' in overcoming such resistance occurs in our experience within the context of contact with individuals with whom one can identify and within sustained relationships with such individuals that are free of contempt and marked by moral equality and emotional authenticity.

Resistance and ambivalence are reduced when people have real choices and are empowered to choose. A research review by Ambrogne[92] drew two important conclusions: 1) people seeking help for AOD problems have better outcomes when they are given multiple options related to goals and methods of help and the opportunity to assert their own choices and control over these options, and 2) people who seek non-abstinent goals are more amenable to abstinence goals when the non-abstinent goals prove to be unattainable or unsustainable.

Medication-assisted Addiction Recovery

Recovery can be achieved with or without medication support—including recovery from opioid addiction with or without methadone or buprenorphine. This position has been supported by major recovery definition consensus conferences in the U.S. and the U.K. The Betty Ford Institute (BFI) Consensus Panel[93] specifically addressed the question of Opioid Treatment Program (OTP) medications and recovery status by defining recovery in terms of sobriety, global health, and citizenship, and then by clearly stating that

> *…formerly opioid-dependent individuals who take naltrexone, buprenorphine, or methadone as prescribed and are abstinent from alcohol and all other nonprescribed drugs would meet this definition of sobriety.*

Similar propositions have been asserted by the U.K.

> *Recovery may be achieved in a variety of ways including through medically-maintained abstinence.*[94]

While some ill-conceived policy documents assert or imply that recovery is conditioned upon cessation of medication maintenance[95] and while much of the international criticism of increased recovery orientation of opioid addiction treatment derives from such narrow

---

[92] Ambrogne, J. A. (2002). Reduced-risk drinking as a treatment goal: What clinicians need to know. *Journal of Substance Abuse Treatment, 22*, 45-53. doi:10.1016/S0740-5472(01)00210-0

[93] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*, 221-228. doi:10.1016/j.jsat.2007.06.001; McLellan, A. T. (2010). What is recovery? Revisiting the Betty Ford Institute Consensus Panel definition. *Journal of Substance Abuse Treatment, 38*, 200-201. doi:10.1016/j.jsat.2009.11.002

[94] UKDPC. (2008). *A vision of recovery*. UK Drug Policy Commission.

[95] Inter-ministerial Group on Drugs (2012). Putting full recovery first. Retrieved May 7, 2013 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recovery-roadmap.pdf

definitions,[96] every effort has been made in Philadelphia to dispel such a limited understanding of recovery. Defining recovery as contingent upon cessation of medications such as methadone or buprenorphine flies in the face of scientific evidence and clinical experience and risks either categorically depriving all people in MAT recovery status or creating a "hierarchy of worthiness, with people whose recovery was supported by medications being looked down on and, in some cases, actively discriminated against."[97]

The original *Recovery-oriented Methadone Maintenance (ROMM)* monograph[98] and subsequent papers co-sponsored by DBHIDS are unequivocal on this point: ROMM is NOT an effort to:

1) Raise the motivational bar of admission to MMT.
2) Limit methadone dosages or the duration of MMT.
3) Define methadone cessation as a criterion for recovery status.
4) Pressure MMT patients to end medication maintenance.
5) Deny or discourage MMT patients access to other treatment modalities or harm reduction information or services.
6) Mandate counseling or peer support services for stabilized patients who do not need or desire such services.
7) Extrude patients who do not adopt the goal of recovery without medication support.
8) Deny stabilized patients access to interim or office-based treatment.
9) Impose remission/recovery criteria on MMT patients different than the remission/recovery criteria applied to all persons with substance use disorders.[99]

To defend the role methadone can play in recovery initiation and maintenance does not mean that MMT is an adequate recovery support system as currently designed. ROMM, as an aspirational vision for MMT in Philadelphia, calls for such changes as:

- increased representation of current/former MMT patients/families at all levels of decision-making within the treatment system,
- assertive approaches to outreach and early intervention,
- accelerated access to services,
- personally optimum dose stabilization,

---

[96] AIVL. (2012). *'New recovery', harm reduction & drug use policy statement*. Australian Injecting & Illicit Drug Users League. Retrieved May 8, 2013 from http://aivl.org.au/database/sites/default/files/New%20Recovery,%20Harm%20Reduction%20%26%20Drug%20Use%20-%20AIVL%20Policy%20Position%20Paper.pdf; McGrail, S. (2012). Opinion: The "new recovery" movement—A warning. Retrieved May 7, 2013 from http://www.nuaa.org.au/index.php?option=com_content&view=article&id=1020:the-qnew-recoveryq-movement-a-warning&catid=41:users-news-issue-no-69-winter-2012&Itemid=92

[97] McGrail, S. (2012). Opinion: The "new recovery" movement—A warning. Retrieved May 7, 2013 from http://www.nuaa.org.au/index.php?option=com_content&view=article&id=1020:the-qnew-recoveryq-movement-a-warning&catid=41:users-news-issue-no-69-winter-2012&Itemid=92

[98] White, W., & Torres, L. (2010a). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center. White, W., & Torres, L. (2010b). Recovery-oriented methadone maintenance (Executive Summary). *Counselor*, *11*(6), 44-53.

[99] White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com

- the use of global, strengths-based assessment protocols,
- phased transition from professionally directed treatment plans to patient-directed recovery plans,
- focused retention strategies,
- a partnership/consultant versus expert relational model,
- development of strong recovery cultures[100] within MMT settings,
- recovery-focused patient/family education,
- an expanded menu of professional and peer recovery support services,
- tri-directional integration of primary health care, mental health care, and addiction treatment,
- assertive linkage to community-based recovery support resources,
- enhanced supports for any patient choosing to taper,
- post-treatment Recovery Check-ups that include stage-appropriate recovery education and when needed, early re-intervention,
- opportunities for recovery advocacy/support and community service, and
- professional and public education about the potential role of medication in recovery initiation and recovery maintenance.[101]

Critical to this understanding of the role medications such as methadone and buprenorphine can play in recovery initiation and maintenance is the distinction between a *drug* and a *medication*. Robert DuPont, MD, and Mark Gold, MD, two long-tenured and leading addiction treatment experts, offer several useful distinctions between psychoactive medications that are used to support health and recovery and psychoactive substances, including medicines, that are used as "drugs."

> *The motivation to use medications is to prevent and treat illness; the motivation to use drugs is brain reward (euphoria). The pattern of using medication is marked by dosages, dosing schedules, and methods of administration that produce steady blood levels of the medication; the pattern of using drugs is marked by dosages and methods of administration (e.g., injection, smoking) that create spikes and troughs in blood levels and an associated escalation in the dosage and frequency of administration. Control and monitoring of medication is maintained via open, honest communication with physicians and family members; drug use is characterized by self-monitoring, a progressive loss of control over drug intake, and secrecy and dishonesty related to the presence or patterns of use. The net effect of medication use is a progressive improvement in quality of life; the net effect of drug use is a progressive deterioration in quality of life. Medication is taken within the laws established to govern its manufacture, sale, possession, and use; drug use (other than alcohol use for adults) often involves breeches of law. To these distinctions might be added that taking medication is often nested within other health-promoting and recovery-enhancing behaviors; drug use is often*

[100] By "strong recovery cultures" we mean visible and diverse recovery role models; language, literature, symbols, art, film and music that promote recovery; close connections with indigenous communities of recovery, and norms within the milieu that inhibit the presentation of "street rituals."

[101] White, W. (2012b). Recovery orientation in methadone maintenance: A definitional statement. Posted at www.williamwhitepapers.com

nested within other self-destructive and socially harmful behaviors. Medication use is also nested within a pro-recovery social network; drug use is often nested within a drug-saturated social network.[102]

Lessons from AATR and HR Integration Experiments

Here are eight critical lessons we have learned from AATR and HR integration efforts within the city of Philadelphia.

AATR and HR integration is not easy. In this stigma-laden arena, efforts to integrate AATR and HR inevitably unfold amidst periodic challenges to each and to integration experiments from the wider political and cultural environment. AATR is under increased scrutiny and criticism[103] and HR faces limited funding, continued areas of complete funding restriction (e.g., ban on federal funds for NSEPs), arbitrary regulations (e.g., efforts to impose limitations on the duration of MMT), discriminatory exclusions (e.g., denial of MMT patients access to residential services), and professional and social criticism. Both AATR and HR programs face stigma-laden neighborhood resistance to siting of new programs and relocation of existing programs. And within the field itself, AATR and HR integration efforts—even the establishment of mutual respect—often requires transcendence of long-standing differences in program philosophies, competition for scarce resources, and competition for leadership within the AOD problems arena. Key areas of integration of AATR and HR principles and practices are possible, but the process requires vision, commitment, mutual support, and patience—not unlike the recovery process itself.

AATR and HR integration is difficult even under the best of circumstances. For example, there is an inherent tension in supporting an individual's self-reported goal of long-term abstinence with the need to provide harm reduction information to address the likelihood of some future episodes of AOD use.[104] Can we, for example, provide support for recovery initiation and maintenance at the same time we provide information on safe injection procedures? That is the dilemma of the caregiver, whether working from an HR or recovery orientation, when working with individuals vacillating between the cultural worlds of addiction and recovery. Within what may be a prolonged course of AOD use and AOD problems, motivation to use, reduce use, or cease use each ebbs and flows, with ambivalence being perhaps the one constant. Great harm can come to self and others during those periods of high use and low motivation for change. HR services provide a means, a safety net, for reducing harm to self or others pending more substantive decisions regarding drug use.

Both AATR and HR as models of intervention must be publicly and professionally defended through the integration process. Integration efforts must promote the cultural legitimacy, clinical effectiveness, and cost-effectiveness of both AATR and HR and the value of integrating AATR and HR principles and practices. We have found it helpful in

[102] White, W. L. (2011a). *Narcotics Anonymous and the pharmacotherapeutic treatment of opioid addiction*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disability Services. P. 35-36

[103] Fletcher, A. M. (2013). *Inside rehab*. New York: Viking.

[104] Koutroulis, G. (2000). "That original tension": Negotiating abstinence in clinicians' accounts of harm reduction in nonresidential treatment of heroin withdrawal. *Journal of Substance Abuse Treatment, 19*, 89-98. doi:10.1016/S0740-5472(99)00087-2

Philadelphia to shift from thinking of this as a major obstacle to thinking of this as a major opportunity for professional and public engagement and education.

Leadership and strategy at multiple levels are essential. For AATR and HR to begin moving from open conflict to peaceful coexistence to collaboration in Philadelphia required political and professional leadership affirming the legitimacy and complementarity of these approaches. Of particular importance was more open support for HR services as a valued component of the behavioral health systems transformation effort. What must be modeled by policy leaders to set the tone for all integration efforts is the theme of collaboration without co-optation or colonization. Also of import are leaders respected by both AATR and HR camps who can serve as hosts, negotiators, and peacemakers. The strategy of integration involved expanding structures of contact (e.g., meetings and forums) that increased relationship building and communication between diverse system constituents and professional and institutional incentives for collaboration and integrated approaches.

Ideas Matter. Both AATR and HR rest on a set of propositions whose validity and universality have been bitterly argued for decades. Some of these propositions reflect value statements while others represent allegations of fact that can be clinically and scientifically tested. Extremists within both sides of the AATR and HR debates are so ideologically committed to their positions (as tenets of faith) that little dialogue is possible; however, the mass of people working in AATR and HR can be engaged in a process of self-examination of these core ideas and through such a process, find areas of common ground. The key is to create a milieu in which debate can move to discussion and where discussion of differences can move to sharing concerns and new possibilities. The ideas outlined in the previous section illustrate some of the bridging ideas that have emerged from this collaborative process in Philadelphia.

Science helps, but stories and direct experience are essential. Injecting the findings of scientific studies related to AATR and HR assumptions and outcomes created windows of openness for self-examination but rarely led to radical shifts in thinking or commitments to AATR and HR integration. What did matter were the following. First, directly experiencing AATR or HR service processes through program visits, staff exchanges, or internships softened previously polarized positions on these services. Second, encounters (hearing the stories of individuals) whose lives had been profoundly helped by AATR and/or HR services offered living proof of the values of these services. That AATR and HR programs exist in silos, physically and culturally isolated from one another, prevents such exchanges unless there is a framework (e.g., the systems transformation planning process) for them to occur. Third, DBHIDS data that programs that had historically had a difficult time retaining individuals who were homeless were effectively engaging, treating and moving these individuals into supportive housing via integrated AATR/HR initiatives changed the attitudes of many of the people who initially resisted such integration..

Relationships matter. The cross-fertilization of AATR and HR principles and practices is not possible without enhancing relationships across the AATR and HR barrier. Both AATR and HR have existed as closed systems—in part because of the culture stigma each faced. For collaboration and cross-fertilization to occur, these systems must be opened via increased boundary transactions—the movement of people, ideas, and materials from one system to the other system. It was our experience that, by

involving people from AATR and HR in system transformation and related planning processes, more respectful and personal relationships were formed between AATR and HR advocates. These relationships were in turn critical to opening both systems up to nuances of change that would not have been otherwise possible.

Money and public/professional recognition matter. The acrimonious debates that had long flourished between HR and AATR advocates involved a competition of ideas, but they also involved a competition for funding and for public/professional recognition. At a national level, extreme shifts toward or away from AATR or HR could reallocate billions of dollars of funding and profoundly influence the fates of community economies, individual organizations, and professional careers. Recognizing this, efforts were made within the transformation process to assuage fears about loss of funding and to bring additional resources into the system that benefited both HR and AATR organizations. Efforts were similarly made to involve and recognize both HR and AATR representatives at key events (e.g., the Mayor's Annual Making a Difference Dinner Awards).

HR and AATR collaborations can be a win/win process. In our review of the scientific literature and our experience of the past decade, we believe there are a number of things that AATR organizations can learn from HR organizations that could enhance AATR effectiveness. The first of these lessons is how to identify and engage those individuals and families with greatest problem severity/complexity and lowest recovery capital who do not currently seek addiction treatment and who are continuing to use drugs in a manner posing risk to themselves and others.[105]

AATR programs have not historically focused on how to support incremental change in active users, including how to reduce harm to and by those who are at present unwilling or unable to achieve abstinence. HR programs have refined a number of "low threshold," strengths-based approaches to service engagement that are worthy of emulation.[106] New AATR service models could similarly be developed by shifting from an exclusively "abstinence only" stance to an "abstinence eventually" stance, with service gradations supporting transitions across multiple stages of change.[107] Of particular importance could be integrating what HR programs have learned about the roles access to stable housing, primary health care, mental health care, and social support can play as precursors to subsequent changes in AOD use.[108] HR programs have also included the voices of active drug users in service design feedback in ways never attempted by AATR organizations.[109] Further, discussions of expanding the goal of addiction treatment to include reducing long-term harm to person, family, and community even for those who choose to continue drug use[110] could extend the AATR's traditionally narrow focus on

---

[105] Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*(1), 13-21. doi:10.1080/02791072.2001.10400463

[106] McQuie, H. (2010). Integrating the spectrum of harm reduction and recovery. Retrieved March 8, 2013 from www.recoverytoday.net/articles/226-harm-reduction-spectrum

[107] Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment, 25*, 241-247. doi:10.1016/S0740-5472(03)00068-0

[108] McQuie, H. (2010). Integrating the spectrum of harm reduction and recovery. Retrieved March 8, 2013 from www.recoverytoday.net/articles/226-harm-reduction-spectrum

[109] Crofts, N., & Kerkt, D. (1995). A history of peer-based drug-user groups in Australia. *Journal of Drug Issues, 25*, 599-616. Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 21*(6), 779-788. doi:10.1016/0306-4603(96)00042-1; Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*(1), 13-21. doi:10.1080/02791072.2001.10400463

[110] Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs, 33*(1), 13-21. doi:10.1080/02791072.2001.10400463

drug use to address multiple high-risk behaviors.[111] There is much AATR organizations could learn from HR organizations' philosophy of personal choice as a service value[112]—something that has only recently been considered as an AATR principle.[113]

There are similarly many things HR organizations can learn from AATR organizations, including the recognition of how choice can be neurologically compromised in the most severe and chronic patterns of addiction, the potential for transformative (sudden, unplanned, positive, permanent) rather than incremental change, and methods for biopsychosocial restabilization after substance use disorder recurrence. AATR organizations could also assist HR organizations in knowledge of indigenous recovery support resources, assertive linkage, and person-group matching procedures to mutual aid groups and other recovery support institutions. Also of potential import would be a greater appreciation of the potential for and processes of recovery as an HR outcome.

HR and AATR are not either/or options. HR services are sometimes castigated for postponing help-seeking and prolonging addiction careers via their perceived "enabling" and thus encouraging drug use and preventing entry into AATR, but such suppositions have not been supported by our experience in Philadelphia or the scientific research. (Also, studies of needle and syringe exchange programs document their capacity to reduce risks at personal and community levels without increasing initiation of drug injecting, increasing the frequency of injecting, or prolonging drug injecting careers.)[114] In Philadelphia, most people engaged through HR services (via assertive outreach, Housing First programs, MMT and NSP) have had past exposure to AATR—often multiple episodes of such involvement over a period of years—or have rejected AATR service and support options. Some studies have shown that providing housing without sobriety as a condition does not increase alcohol and drug use when compared to control groups where such a condition is imposed, and they also show that stable housing can serve as a platform for recovery initiation.[115] There are many people in recovery within the City of Philadelphia who entered recovery through HR portals.

Alcohol and drug dependence takes an inordinate toll in terms of personal morbidity and mortality. Keeping drug dependent individuals alive and preventing or reducing the burden of damage to self and others during periods of active drug use is an important goal even in the presence of other longer term goals (e.g., sustained recovery from a substance use disorder).[116] As one HR/AATR integration advocate bluntly explained to the authors, "Dead people don't recover."

Drug users may be viewed as "incompetent and pathological" and thus only "objects of intervention" or as "allies and participants in their own individual and

---

[111] Marlatt, G. A. (1996). Harm reduction: Come as you are. *Addictive Behaviors, 21*(6), 779-788. doi:10.1016/0306-4603(96)00042-1

[112] Lenton, S., & Single, E. (1998). The definition of harm reduction. *Drug & Alcohol Review, 17*, 213-220. doi:10.1080/09595239800187011; Denning, P. (2001). Strategies for implementation of harm reduction in treatment settings. *Journal of Psychoactive Drugs, 33*(1), 23-26. doi:10.1080/02791072.2001.10400464

[113] White, W. (2008). Toward a philosophy of choice: A new era of addiction treatment. *Counselor, 9*(1), 38-43.

[114] Wodak, A., & McLeod, L. (2008). The role of harm reduction in controlling HIV among injecting drug users. *Aids, 22*(suppl 2), S81-S92. doi:10.1097/01.aids.0000327439.20914.33

[115] Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

[116] Harm Reduction International. (2013). What is harm reduction?" Retrieved March 16, 2013 from http://www.ihra.net/what-is-harm-reduction; Wodak, A. (1994). Olympian ideas or pragmatism. *Addiction, 89*, 803-814. doi:10.1111/j.1360-0443.1994.tb00975.x

collective health."[117] Active drug users, even in a state of drug dependence, can alter patterns of use to reduce risks (e.g., HBV, HCV, HIV infection; death from overdose) related to use.[118] People who are cycling in and out of recovery face special risks and are in need of elevated supports.[119] Addiction treatment can be coerced by all manner of external pressure but recovery cannot; recovery can only flow from personal choice.[120]

Recovery initiation is as much about the experience of hope as it is about the accumulation of pain. HR programs have been viewed as antithetical to recovery in part from the perception that they prolong addiction careers by preventing or delaying the experience of "hitting bottom"—an experience viewed by many AATR advocates as a critical catalyst of recovery initiation. But HR programs may provide a different form of catalyst via increases in self-efficacy and recovery capital.

> *We reject the notion that people have to "hit bottom" to move from addiction to recovery. Such bottoms are as likely to result in prolonged disability or death as positive transformation. Our position is that hope and growing aspirations for a better life can be a catalyst to recovery as much as a desire to escape addiction-related pain. Our intent is to affirm the recovery option in every encounter with individuals and families experiencing AOD problems and to provide the support that makes this movement toward health possible—either as a sudden dramatic leap or a process involving incremental steps over time. This welcoming doorway of hope must always be open.*[121]

Working to prevent immediate harm does not preclude those working in NSPs and other HR programs from also serving as recovery carriers via the transmission of hope for long-term recovery.

AATR and HR are the products of heterogeneous social movements made up of constituency groups with widely varying philosophies and service practices, all of whom cannot be expected to approve of or participate in processes of collaboration. Each movement has a radical wing that views any form of AATR and HR collaboration as ideologically unacceptable. That said, the mainstream of each movement seems to be moving from viewing AATR and HR as binary choices to viewing AATR and HR as complementary. In this emerging view, AATR and HR exist on a continuum of choices available to people who use drugs or wish to cease such use. Anyone presently proposing blending of AATR and HR philosophies and practices can expect criticism from the radical wings of both movements even as the trend toward hybrid models of AATR and HR leave these radical wings increasingly isolated.

HR and AATR integration must be bi-directional. Integration is not one side winning the ideological or service design battle but both sides developing mutual respect

---

[117] Friedman, S. R., de Jong, W., Rossi, D., Touźe, G., Rockwell, R., Des Jarlais, D. C., & Elovich, R. (2007). Harm reduction theory: Users culture, micor-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups. *International Journal of Drug Policy, 18*(2), 107-117. doi:10.1016/j.drugpo.2006.11.006

[118] Friedman, S. R., de Jong, W., Rossi, D., Touźe, G., Rockwell, R., Des Jarlais, D. C., & Elovich, R. (2007). Harm reduction theory: Users culture, micor-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups. *International Journal of Drug Policy, 18*(2), 107-117. doi:10.1016/j.drugpo.2006.11.006

[119] Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use, 18*, 56-64. doi: 10.3109/14659891.2013.761024.

[120] Wisely, C. (2013). The logic of recovery and injection drug use. *Journal of Substance Use, 18*, 56-64. doi: 10.3109/14659891.2013.761024.

[121] Personal Communication, Dr. Arthur Evans, Jr. March 20, 2013

and a commitment to explore common ground and the potential for new approaches to protecting and promoting the health and safety of individuals, families, and communities not historically included within either perspective.

Conclusion

Harm reduction and abstinence approaches for the management and resolution of AOD problems have often been presented as binary choices within what have often been vitriolic debates within the AOD problems arena. At a policy level, there has similarly been a tendency for governments to focus on one or the other of these strategies while marginalizing the alternative. What we have attempted to explore in this article is how such approaches might be more effectively integrated to achieve greater balance at both social policy and service practice levels.

Spurred on by a philosophy that holds long-term recovery as the ultimate goal for all individuals with AOD problems, considerable efforts have been exerted by the City of Philadelphia to achieve integration of AATR and HR approaches. However, many questions remain about the desirability, mechanics, and outcomes of such integration. What is clear is that the chasm between HR and AATR principles and practices is being bridged with hybrid approaches that integrate public health and clinical perspectives. Such integration may well constitute the future for the management of the most severe, complex, and chronic AOD problems.

Public health and medical models of intervention into AOD problems can each result in a depersonalization of the very people they are intended to serve.[122] Resilience and recovery perspectives may offer a way to humanize both approaches while retaining their most valuable elements. Hybrid models that blend elements of HR and AATR may be particularly well-suited for individuals and families who have been difficult to reach, engage, treat, and reintegrate into mainstream community life through traditional service programs.

There is a question we continue to confront locally, nationally, and internationally. That question is whether existing social institutions competing for cultural and financial ownership of AOD problems can transcend their ideological divisions to forge new collaborative, integrated models of intervention that address the whole spectrum of AOD problems. The fate of these institutions and the health of nations may well rest on the outcome of this question.

Acknowledgement: We would like to thank the following individuals for their assistance in preparing this report: Eugenia Argires, José Benitez, Marvin Levine, Marcella Maguire, Tim Sheahan, and Carl Pray. We also wish to express our appreciation to Dr. David Best and Dr. John Strang who provided valuable feedback and suggestions on a first draft of this paper.

About the Authors: Arthur. C. Evans, Jr., PhD, (Arthur.C.Evans@phila.gov) is Commissioner of the Philadelphia Department of Behavioral Health and Intellectual disAbilities Services (DBHIDS). William White (bwhite@chestnut.org) is Emeritus

[122] Miller, P. G. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health, 11*(2), 167-178. doi:10.1080/09581590110039865

Senior Research Consultant at Chestnut Health Systems and a consultant to DBHIDS. Roland Lamb (Roland.Lamb@phila.gov) is Director of the Office of Addiction Services, DBHDIDS.



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. (2013). State of the new recovery advocacy movement. Posted at **www.williamwhitepapers.com**

State of the New Recovery Advocacy Movement
Amplification of Remarks to the Association of Recovery Community Organizations at Faces & Voices of Recovery Executive Directors Leadership Academy Dallas, Texas, November 15, 2013

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

It is always good to be with old friends, friends in recovery and friends of recovery. It is a special pleasure to finally meet some of you face-to-face who I have corresponded with for so many years. As I entered the worlds of addiction treatment and recovery in the late 1960s, I witnessed the end of a very dark era in our country—an era in which those with alcohol and other drug problems festered in the "drunk tanks" of local jails and the "back wards" of aging state psychiatric hospitals or died alone bereft of hope. Few resources existed in most communities outside the rooms of mutual aid fellowships.

It would have been unthinkable in those early days that I would live to see a national network of addiction treatment and recovery support resources and the rising cultural and political mobilization of people in recovery. I could not have conceived of a day when I would witness more than 100,000 people in recovery marching publicly as far as the eyes could see or that I would one day stand before leaders of new recovery advocacy organizations from all over the United States. And yet we all witnessed the unprecedented numbers in recent Recovery Month celebration events, and I am here today living out the second of those unthinkable visions. I have been invited as the historian of this movement to share some thoughts with you about the current state of recovery advocacy and support in the United States. In the few minutes we have together, I want to share some of my personal perspectives on our accomplishments to date, current and anticipated threats, and the movement's next stages, strategies, kinetic ideas, and frontier issues.

New Recovery Advocacy Movement Achievements

We would not be here today if those at the center of this emerging movement in the late 1990s and early 2000s had not made some very good decisions. I want to record some of the decisions that in retrospect I think were most important.

Historical Continuity. The first thing we got right was maintaining historical continuity with, and paying tribute to, earlier recovery advocacy efforts. We honored the past and continuing achievements of the National Council on Alcoholism and Drug Dependence (NCADD), the Johnson Institute as well as the earlier work of such organizations as the Society of Americans for Recovery (SOAR). By entering the alcohol and drug problems arena from a position of gratitude, humility, and respect and by grounding our movement in core recovery values, we minimized competition and conflict with kindred individuals and organizations. The embrace of such a partnership model continues to serve us very well.

Decentralized Leadership. Social movements are often fueled by charismatic leaders who are then prone to wrap themselves in closed organizations that become progressively disconnected from their grassroots constituencies. Perhaps because of our collective character (organizing people in recovery has been compared to trying to herd cats), we have avoided the pitfalls of aligning ourselves under the umbrella of a charismatic leader, and we have maintained our local, grassroots focus. I can recall early on the confusion of the media when we were asked who the leaders were of this new movement and we declared either that we had no leaders or that we were all leaders. We got this right.

Cultural and Recovery Pathway Diversity. What we have achieved was born within a profound respect for the diversity of recovery experience and the legitimacy and wonder of such diversity. We spoke of a rainbow and a coat of many colors to capture our vision of a most culturally diverse movement, and we shared an ecumenical vision of a day when AA and NA members would walk beside people in secular recovery, faith-based recovery, medication-assisted recovery, and natural recovery with each of us not wearing our pathway identities but a larger identity: people in long-term recovery.

"The Little Engine that Could". We decided early on to act as if we were a movement of import until we became one. We began referring to ourselves nationally and locally as a movement, acting far more bold than our early numbers would have warranted, and we documented our history via papers, recorded interviews, and visual images in the belief that what we were doing was historical and thus important to document. It was and is.

Kinetic Ideas. As early as 2000, five simple ideas emerged from the very heart of the movement—ideas that were foundational and kinetic (capable of inspiring action). Those five ideas were: 1) addiction recovery is a living reality for individuals, families, and communities, 2) there are many (religious, spiritual, secular) pathways to recovery, and all are cause for celebration, 3) recovery flourishes in supportive communities, 4) recovery is a voluntary process, and 5) recovering and recovered people are part of the solution: recovery gives back what addiction has taken from individuals, families, and communities. In retrospect, the selection of this particular set of ideas was critical to avoiding the schisms that have destroyed so many social movements. The first two of these ideas became the foundation for much of the consciousness raising and

mobilization that went on in the early years and that continues today.

Core Strategies. The vision in the late 1990s was to change public attitudes and public policies to create recovery-friendly communities. We believed that such communities could shorten addiction careers, support individuals and families in long-term recovery, and ultimately break intergenerational cycles of addiction within our families, neighborhoods, and communities. As early as 2000, eight core strategies were being pursued within newly formed recovery community organizations (RCOs).

1. Building strong, grassroots recovery community organizations (RCOs) and linking these RCOs into a national movement that would develop recovery leaders, offer opportunities for the recovery community—people in recovery, family members, friends, and allies—to express their collective voice, respond to community-identified recovery support needs, and provide a forum for community service.
2. Advocating for meaningful representation and voice at local, state, and federal policy levels for people in recovery and their family members on issues that affect their lives.
3. Assessing needs related to the adequacy and quality of local treatment and recovery support services.
4. Educating the public, policymakers, and service providers about the prevalence and pathways of addiction recovery.
5. Developing human and fiscal resources by expanding philanthropic and public support for addiction treatment, recovery support services, and recovery advocacy and by cultivating volunteerism within local communities of recovery.
6. Creating recovery community centers that make recovery visible on Main Street and provide a setting for non-clinical, peer-based recovery support services, supports, and activities.
7. Celebrating recovery from addiction through public events (recovery marches, rallies, concerts) that offer living proof of the transformative power of recovery.
8. Supporting research that illuminates the pathways, processes, stages, and styles of long-term personal/family recovery.

Several things made development and refinement of these strategies possible, but two were critical. First was creation of a mutual learning community that brought RCO leaders together to expand their knowledge, develop expertise, and cultivate and refine best practices. The early development of this network was made possible by the networking that occurred in tandem with NCADD meetings and meetings of the Center for Substance Abuse Treatment's Recovery Community Support Program (RCSP) grantees. These early RCO exchanges set the stage for the historic 2001 Recovery Summit in St. Paul, Minnesota, the founding of Faces and Voices of Recovery, and the subsequent development of the Association of Recovery

Community Organizations (ARCO). Faces and Voices of Recovery and ARCO have since provided the connecting tissue that links RCOs throughout the country. Collectively, these forums provided a mechanism for RCO leaders to share what was working and not working at local levels and to generate consensus on issues critical to the national movement. A second influence on strategy development was the early decision to use formal data collection and analysis to formulate and refine movement strategy and tactics. An early example of that was the Peter Hart Public Opinion Survey on recovery in which we discovered to our dismay that most Americans had little recognition of the larger number of Americans living in long-term stable recovery and instead saw recovery as a process of trying to stop alcohol and other

drug use but not the achievement of this goal.

Message Clarity. The data collection and analysis allowed us to formulate a clear set of messages that could be used by RCOs throughout the country and would be disseminated via "message training" that clarified the meaning of recovery and reality of long-term recovery in public communications. A further critical step in that message clarity was the work of detailing how advocacy could be done in ways that were completely in alignment with the anonymity traditions of 12-Step recovery programs—a position recently reaffirmed via a widely disseminated communication from the General Service Office of Alcoholics Anonymous. *Early Strategic Partnerships.* As the movement began to spread, we needed models that could guide how RCOs could relate to and collaborate with a wide spectrum of organizations. These models emerged from several key partnerships including with the Center for Substance Abuse Treatment at the national level and models of collaboration with state and municipal organizations that were pioneered by the Connecticut Community of Addiction Recovery and the work of PRO-ACT in the City of Philadelphia. Later, the Association of Persons Affected by Addiction in Dallas collaborated with a major managed behavioral healthcare organization on what has become a model of private reimbursement for peer recovery support services. *Support for Movement Globalization.* Another early thing we got right was extending ourselves to support rising recovery advocacy movements in the UK, Asia, Africa, Australia, and Canada. We did this by accepting invitations to speak in these countries and by hosting innumerable visits from recovery advocates across the globe. The fruits of those efforts are quite remarkable, such as major recovery parades in four Japanese cities in recent months—something that would have been unthinkable during our first visits there in 2007. The service ethic that inspired the recovery advocacy movement in the U.S. is now reaching around the world. *Early Advocacy and Peer Recovery Support Development Successes.* As a result of the above key decisions, we have much to be proud of in 2013. We have witnessed:

- increased recovery representation at national, state, and local policy levels and key policy successes,
- the emergence of recovery as an organizing paradigm for addiction policy and service practice,
- major efforts to reconnect addiction treatment with the larger and more enduring processes of personal/family recovery via models of sustained recovery management and recovery-oriented systems of care,
- mass mobilization of communities of recovery via highly successful recovery celebration events, e.g., marches, rallies, festivals, and town meetings,
- the spread of new recovery support institutions—RCOs, recovery community centers, recovery residences / National Association of Recovery Residences, recovery schools / Association of Recovery Schools, recovery industries, recovery ministries,
- exponential growth of peer recovery support services (PRSS), new peer service roles (e.g., recovery coaches) and PRSS practice standards (Council on Accreditation of Peer Recovery Support Services), and
- increased interest in recovery within the addictions research community.

Today, the new recovery advocacy movement in America is coming of age.

Current and Anticipated Threats

To acknowledge our achievements to date is not to ignore significant threats—some common to all social movements and some unique to the recovery advocacy movement. Here are some current and anticipated threats.

Mobilization without Institutionalization. All social movements risk mistaking methods for mission and getting frozen at an early stage of movement development. We must avoid infatuation with the growing numbers of people participating in recovery celebration events and continually ask and answer, "Mobilization for what purpose?" Mission clarity is critical to movement maintenance.

Implosion. All social movements at national and local levels are prone to centralized leadership, ideological closure, leadership and core membership exhaustion and the collapse of key organizations. These processes often spawn major schisms and mass movement defections. The greater the centralization of leadership, the greater is the risk of such things occurring. Strategies of leadership development, succession planning, and participatory models of decisionmaking are crucial preventatives and antidotes to such processes.

Colonization/Professionalization/ Commercialization. All social movements are at risk of being hijacked by more powerful forces within their operating environment. Because of the early alignment with the addiction treatment system following the 2002 CSAT/RCSP decision to no longer fund recovery advocacy efforts and to only fund recovery support services, there has been a parallel shift in emphasis in the larger movement toward PRSS with a somewhat diminished focus on advocacy and recovery community development and mobilization activities. This has exerted pressure towards professionalization and commercialization of PRSS. My primary warnings in this area are as follows. If the recovery advocacy movement morphs solely into a PRSS appendage to the addiction treatment system, the movement will have failed and will recreate conditions that will set the stage for a future revitalized recovery advocacy movement. (One could argue that this was in fact the earlier fate of the recovery advocacy movement of the mid-twentieth century.) If PRSS become fully professionalized and overly commercialized, they will lose their experiential foundation and do substantial harm to the voluntary service ethic that has long been the foundation of communities of recovery in the U.S. Accreditation, and credentialing related to PRSS must come from within or be controlled by central institutions within the recovery advocacy movement to avoid such pitfalls.

Marginalization. The movement faces two major threats of marginalization into insignificance. If we cannot achieve significant representation/influence in restructuring of addiction treatment within the current processes of health care reform, we risk PRSS becoming disconnected from these mainstream systems, which would mean that the majority of persons seeking professional help would not have PRSS integrated as part of their treatment and continuing care plans. There are also widespread initiatives to integrate addiction treatment with mental health and primary health care. There is a risk that recovery representation and core knowledge of addiction recovery could be lost within such integration initiatives, leading to a death by dilution of addiction treatment and the recovery advocacy movement. It is quite appropriate for us to reach out to sister movements, but great care must be taken to keep our "eyes on the prize" and not lose our addiction recovery focus.

The Coming Professional/Cultural Backlash. No successful social movement

has avoided a cultural backlash. Such backlashes are spawned by excesses within the movement itself and by established interests who experience threat from the movement's achievements and potential power. Such backlashes are intensified when they allow full expression of dormant prejudices related to highly stigmatized issues, e.g., addiction.

I would point out three potential wolves at our door seeking vulnerability points of the movement to exploit for their benefit. The first is the media. The same media that extols the virtues of the newly visible recovery advocate and thrusts the advocate on a high cultural pedestal will also lead the vulture-like feeding frenzy at the first sign of the fall of such a leader.

The media's primary mission is to sell products, which they do by cultivating themes antithetical to recovery stability and quality: crisis, drama, hysteria, emotional excess, self-promotion, self-indulgence and shame. The media can use us just as we can use the media, but let's be very clear: the media as a social institution is not our friend.

The second wolf at our door is a sector of the addiction treatment industry that fears the potential power and influence of politically mobilized recovery communities. This sector includes organizations that view addicted people as a crop to be harvested for financial profit, organizations who fear close scrutiny of addiction treatment outcomes, those who fear the demands a mobilized recovery community will make to elevate the quality of addiction treatment, and those who fear the diminished allocation of status and resources to treatment organizations that may accompany a broadened focus on long-term addiction recovery.

The third wolf at our door represents the interests of the alcohol, tobacco, pharmaceutical, and illicit drug industries. Such powerful industries have little concern with our recovery support activities, but some of our advocacy activities pose great threats to their future. Of particular concern would be our exposure of the predatory practices of these industries; our efforts to expand recovery-friendly, ATOD-free space within local communities; our support for limitations on ATOD advertising (particularly to vulnerable populations); and our support for increased ATOD taxation to offset social costs of ATOD use and to support ATOD prevention, treatment, and recovery support efforts. These industries as a collective force are not our friends and constitute very powerful and formidable opponents. There are major ethical issues related to any relationship with these industries, including acceptance of proffered funding. When these forces coalesce, attacks to undermine the credibility of recovery advocacy organizations and leaders could be quite personal and intense. There are several steps needed to protect our leaders and our organizations. These steps include 1) rigorous adherence to financial stewardship, best practices related to fiscal management, and financial transparency of our organizations, 2) development of ethical guidelines and ethical decision-making models to guide recovery advocacy and peer recovery support services, 3) rigorous self-evaluation and training related to how private behavior could harm leadership and organizational credibility, and 4) making sure the "faces and voices" of this movement are diverse and constantly rotating to minimize the targeting of any core leadership. Finally, when any person who has been a visible part of the movement experiences a fall from grace, whether through a recurrence of addiction or other delegitimizing behavior, it is important that we offer that person our full support for recovery re-stabilization, as we would for all others in need of such support.

The Future of the Movement

I want to reference four issues to open the discussion of the future of the recovery advocacy movement in the U.S.

Continual Representation Checks. First, as we go forward, it is important that we regularly self-inventory the degree of recovery representation within our organizations, as well as the authenticity (e.g., avoidance of double agentry[1]) and diversity (e.g., gender/age/culture/pathway representation) of such representation. The degree, authenticity, and diversity of indigenous representation often erode as social movements evolve toward formal organizations. The legitimacy and continued renewal of the new recovery advocacy movement rests on these representation issues.

Clarity of Advocacy Agenda. The future of the new recovery advocacy movement also rests on our ability to freshen and contextually refine the vision and goals of the movement. These must be defined at both national and local levels through processes of consensus-building. I will shortly note new elements within that agenda that I think are important for us to consider as we move forward.

Institution Building. We are moving beyond the stage of consciousness raising and cultural/political mobilization to the stage of institution building. We are enhancing the infrastructures of existing RCOs; facilitating the geographical dispersion of RCOs; and expanding and creating new recovery community centers, recovery residences, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-focused sporting clubs/events, and recovery media outlets. These are the structures through which the movement will sustain itself in the years to come.

Cultural Development. We are also well on our way to constructing an ecumenical culture of addiction recovery in the United States with its own language, symbols, rituals, values, literature, art, music, theatre and film products, sporting teams, etc. Its ecumenical nature implies that it incorporates elements from diverse pathways of recovery but is distinct from and unaffiliated with any particular pathway of recovery. What such a culture provides is the psychological and social space within which one can recover within a local community—space that is particularly important for people who have been deeply enmeshed in and are trying to extricate themselves from a culture of addiction.

Economic Development. I believe the next stage of movement development will be one of economic development. I envision a day soon when recovery community centers across the country will collaborate with recovery-friendly businesses and serve as incubators for small businesses started by and employing people in recovery. Such businesses will be particularly valuable for people in recovery who have been marginalized from the mainstream economy and/or who face special obstacles to employment due to their re-entry into the community from jail or prison. And I see a growing cadre of recovery philanthropists (large and small) investing in this economic development as well as supporting our core organizations.

Constituency Expansion

Another critical step as we move forward is in the area of constituency expansion. The involvement of Native American organizations (particularly White

[1] Double agentry is an ethical issue that occurs when a person presents themselves as a person in recovery but actively represents other undeclared personal or institutional interests.

Bison, Inc.) and recovery advocacy organizations with high African American representation (e.g., in cities such as Atlanta, Baltimore, Chicago, Dallas, Detroit) exerted a profound influence on the early recovery advocacy movement, but greater effort is needed to mobilize recovery constituencies within Hispanic and Asian Communities.

I have been particularly excited by the development of Young People in Recovery (YPR). We have the largest generation of young people in recovery in history. Focused leadership development efforts over the next few years could reap rewards for decades. We should all be supporting YPR infrastructure expansion and support continued cultural diversification as the youth branch of the recovery movement expands.

Another growing group that could exert a profound influence on the future of the movement is retirees in recovery—a group that brings an enormous reservoir of skills, time, and financial resources.

Family members of individuals recovering from addiction have been welcomed since the early days of the new recovery advocacy movement, but we are now witnessing something on an unprecedented scale in the U.S. and other countries: the mobilization of people who are transforming grief over the drug-related death of a loved one into advocacy and political action. It remains to be seen whether these grieving family and friends will form their own movement or become a new constituency and a new set of voices within the recovery advocacy movement. I am suggesting that we warmly welcome them at all levels of the movement and that their support be embraced within the movement's recovery focus.

Next Kinetic Ideas

There are several newly emerging and interconnected ideas worthy of infusion into our work. Here are those I consider the most important.

Recovery is Contagious. This phrase suggests that recovery can be "caught"—interpersonally transmitted—before it is chosen. Recovery is spread through exposure to *recovery carriers ("wounded healers")*—people who make recovery infectious through their persona and their love and service to those still suffering. Positing the contagiousness of recovery counters the ideas that people must "hit bottom" before recovery is possible and that family and community are powerless to affect addiction until the addicted person is "ready" for recovery. This notion of contagiousness suggests quite the opposite: that recovery initiation has as much to do with hope as with pain, and that hope can be elicited through interpersonal encounters with people living vibrant, meaningful lives in recovery.

Recovery prevalence (the number of people in addiction recovery within a community) can be strategically increased by increasing the density of *recovery carriers* within that community. This can be done by recovery resource mapping—identifying areas of a city in greatest need of recovery support resources—and infusing such resources via assertive outreach and recovery community development activities. Increasing the visibility of recovery carriers counters community pessimism related to addiction by elevating recovery as an expectation by affected persons, professionals, and the community.

Recovery prognosis is predicted as much by community recovery capital as by personal vulnerabilities and assets; recovery-hostile communities can be transformed into recovery friendly communities. We are currently placing people with severe, complex, and prolonged

addiction careers within treatment designs whose brevity and low intensity produces little likelihood of a positive recovery outcome. When resumption of addiction then occurs, as it does so often, the individual is blamed and punished (via divorce, loss of child custody, revocation of probation, job dismissal, expulsion from school, etc.) on the grounds that "they had their chance and blew it." I'm suggesting that such a scenario was not a chance, but a set-up for failure—and as much a community systems failure as a personal failure. Recovery stability is enhanced by effective, accessible, affordable resources designed to support long-term personal and family recovery. Anything less is analogous to treating a bacterial infection with half of the needed antibiotics and then blaming the patient when the infection returns in a more intractable form. *Whole communities have been wounded by severe AOD (alcohol and other drug) problems and are in need of a process of community recovery.*

Personal and community recovery is enhanced by expanding recovery-friendly space— physical, psychological, and cultural space where recovery can flourish. Such space can be measured and expanded through strategic and sustained initiatives of recovery community resource development. I think this idea of recovery-friendly space will become increasingly important to the future work of the movement and that we will come to fully appreciate the powerful role people in recovery can play as catalysts of *community healing* via their person/family-centered and broader community service work

What we don't know about recovery is killing people. Recovery advocates have been calling upon (i.e., begging and pleading) the National Institutes of Health—the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism—to pursue a recovery research agenda for more than a decade. The prolonged governmental failure to develop and substantially fund a clearly define, solution-focused, recovery research agenda to elucidate the prevalence, pathways, processes, stages, and styles of personal/family recovery contributes to the loss of life from addiction and compromises the quality of life of individuals and families in recovery. Some of the most critical questions related to recovery initiation and maintenance—the questions most critical to individuals/families needing, seeking and in recovery--remain unanswered. This is completely unacceptable. Our approach to NIH/NIDA/NIAAA on this critical need must become more confrontational and engage the constituencies and political powers to which the Institutes are accountable. Media dissemination of the existing research focus with its obsession with "hijacked brains" may, by increasing rather than decreasing social stigma related to addiction, be doing more harm than good to people in need of, seeking, and in recovery.

Frontier Issues

There is still much work to be done laying the foundation for the recovery advocacy movement at national, state, and local levels. Early movement stages must be continually replicated and refined via consciousness raising, mass mobilization, RCO infrastructure enhancements, advocacy on emerging issues, and peer support service refinements, but there are also frontier issues on the horizon for us to consider. Here are a few.

Recovery Responsibilities. I suggest a shift in the public face of the movement from a focus on the rights of people in recovery (though our advocacy work will continue) to a focus on *recovery responsibilities* to family and community. This would shift our emphasis from self to service. Addiction has been correctly portrayed as destructive to family and community fabric; we must use science and

our stories to demonstrate recovery as a healing and restorative force within the life of family and community.

Family and Community Service constitute the needed third leg of the movement—along with advocacy and peer recovery support. That third leg provides a means of both making needed amends to family and community and elevating the visibility of the service ethic beyond service to individuals in recovery. The "face" of the movement must expand beyond recovering individuals—whom the public tends to view as self-centered and self-indulgent due to the media's obsession with self-destructing celebrities—to the image of families in recovery. The demonization of the person affected by addiction will continue until we positively (and visually) nest that person in the context of family, friends and community. In that same vein, it is also time we explored more consciously an expanded role for children within the movement—a potential that was critical within the respective histories of the civil rights and LGBT rights movements.

Breaking Intergenerational Cycles. I think THE recovery advocacy issue of the 21st century is breaking cycles of intergenerational transmission of addiction and related problems. We need to assemble the best minds and best science we can muster to formulate a decades-long plan to achieve this goal and then mobilize the political power to initiate and sustain such an effort.

Health Status of People in Recovery. Marketing of the acute care model of addiction treatment in the U.S. feeds the illusion that people go through brief treatment, initiate recovery, and live happily ever after. While there are people whose recovery stories have that flavor, this portrayal of recovery masks what is often a much more complex process of recovery initiation, stabilization, and maintenance. It also fails to accurately portray the many burdens—including health burdens often brought into the long-term recovery process—burdens clearly revealed in a recent recovery prevalence and health study from Philadelphia. The recovery advocacy movement of the future will recognize such enduring challenges and expand its focus beyond recovery initiation to a broad spectrum of advocacy efforts, programs, and services aimed at enhancing the health and quality of life of individuals and families in long-term recovery. Those efforts must include a focus on the issue of nicotine addiction, which continues as a major cause of disease and death for people in recovery from other addictions.

Recovery Advocacy/Support within the U.S. CJ/Jail/Prison System. The United States has the largest sequestered and monitored population of addicted people in the world. We as a movement should be recruiting and developing indigenous recovery leaders within the very heart of these institutions. I believe we will see a major recovery advocacy movement rise within U.S. jails and prisons in the next decade. It is important we not turn our back on this rising movement. We need to help seed this movement, build recovery supports within the criminal justice system, and help create recovery-supportive pathways for community reentry.

Leadership Self-maintenance

What my historical perspective has given me is an understanding that our present work is nested within a prolonged historical struggle to forge personal, community, and cultural solutions to the most severe and complex addictions. Thus my mantra to all recovery advocates is: "Pace yourself; this is a marathon!" So the question remains, "How does one sustain oneself through such a long journey?" I have seen people burn themselves out (and

occasionally self-destruct) from the intensity of this work, but I have also observed people doing this work with great dignity, grace, and health for decades. I've found four daily rituals that distinguish the lives of this latter group that I would like to share with you.

The first is centering rituals: daily self-appraisal, goal-setting, and meditation/prayer that help keep one's "eyes on the prize" and help maintain personal integrity. Such rituals also keep one focused on the primacy of personal recovery by reminding us that recovery advocacy is not a program of personal recovery.

The second is mirroring rituals: regular communion with mentors and kindred spirits who share our passion for this work.

The third is acts of self-care: personal repair and replenishment, but this also includes care for one's family and other primary relationships. The best advice I have ever been given as an advocate is captured in the following statement: "*One must be careful when carrying light to the community to not leave one's own home in darkness."*

The fourth replenishment ritual is unpaid acts of service outside of our advocacy activities. These activities exercise our service muscles and connect us to kindred spirits outside the world of addiction recovery.

Closing

I have had the great honor of serving as the historian of the new recovery advocacy movement since its earliest days. From the beginning, those of you on the front lines of this movement have been my heroes. In 2001, I challenged you in St. Paul to go make some history, and that's precisely what you did. I sleep well knowing that the future of addiction recovery in America is in your hands.

About the Author: William White has worked as a volunteer consultant for Faces and Voices of Recovery since its inception and is author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* and *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement*.



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. & Tuohy, C.M. (2013) Recovery-oriented practice and the addictions professional: A systems perspective. *Advances in Addiction and Recovery* (NAADAC), Summer Issue, pp. 22-23. Posted at www.williamwhitepapers.com

Commentary
Recovery-oriented Practice and the Addictions Professional: A Systems Perspective

William L. White, MA and Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP

Modern addiction treatment as a system of care emerged in the early 1970s. This birthing process was followed by sustained and turbulent processes of professionalization, commercialization, and bureaucratization. New specialized addiction treatment programs were a godsend for people with alcohol and other drug problems and their families who in earlier years faced few if any resources, contempt from mainstream helping professionals, and all too often, harmful interventions masked as help. Today, hundreds of thousands of people in long-term recovery owe their lives to modern addiction treatment. So why in the past decade have we witnessed repeated calls from people in recovery and from long-tenured addiction professionals for greater recovery orientation in addiction treatment? Aren't addiction treatment and addiction counseling already recovery-oriented? In this brief essay, we will offer some historical perspectives and systems performance data to answer these questions.

Lost Connection to Recovery

There are remarkable milestones in the rise of a national infrastructure of addiction treatment, each worthy of a detailed recounting: discovery of replicable models of addiction treatment, expansion of public and private funding for addiction treatment, explosive growth of community-based treatment programs, development of program accreditation and counselor certification standards, birth of professional associations and addiction studies programs, and increased rigor addiction research, to name just a few. Yet, by the mid-1990s, as addiction treatment episodes became ever-briefer, there were warning voices suggesting that something important was being lost in the professionalization and industrialization of addiction treatment. One could hear at national conferences and read in the field's professional journals fears that addiction treatment was becoming disconnected from the larger and more enduring process of addiction recovery and that recovery initiation in institutional settings was disconnected from processes of recovery maintenance within natural community environments (Elise, 1999;

Morgan, 1994; White, 2004). A growing recovery advocacy movement also challenged that an addiction treatment field that once viewed itself as an adjunct to recovery was now viewing recovery as an adjunct (afterthought) to itself (White, 2001).

Key System Performance Measure

The opening decade of the 21st century witnessed two additional shifts that exerted a profound influence on addiction treatment. The first was the refined conceptualization of addiction as a chronic condition (McLellan, Lewis, O'Brien, & Kleber, 2000) and discussions of the implications of such an understanding to clinical practices in addiction treatment (Dennis & Scott, 2007; White, Boyle, & Loveland, 2002). The second shift involved an intensified analysis of what addiction treatment was and was not achieving as a system of care. Critiques of key system performance measures (e.g., White, 2008a) concluded that there were major problems with addiction treatment in such key areas as 1) attraction and access (only 10% of those with a substance use disorder enter treatment each year), 2) engagement and retention (less than 50% successfully complete treatment, 3) clinical practices (significant gaps between clinical research and clinical practices, 4) linkages to communities of recovery (use of passive rather than assertive linkage procedures), 5) service duration (less than optimum 90 days across levels of care), 6) continuing care (only 20-36% of adolescents and adults receive post-treatment monitoring and support), 7) post-treatment substance use outcomes (more than 50% of persons leaving treatment resume substance use within year of discharge, with most occurring within 90 days of leaving treatment), and 8) treatment recycling (64% of persons entering addiction treatment have a prior treatment; 19% have 5 or more prior treatment episodes).

Recovery as an Organizing Paradigm

These processes of professional self-inventory and systems performance evaluation triggered calls to: 1) shift the field's organizing center to one focused on recovery rather than addiction pathology or clinical/social intervention, 2) extend the design of addiction treatment from one focused almost solely on acute biopsychosocial stabilization (recovery initiation) to one that encompassed support for long-term personal and family recovery (recovery maintenance and enhanced quality of life in recovery), and to 3) nest these models of sustained addiction recovery management (ARM) within larger recovery-oriented systems of care (ROSC; White, 2005, 2008a,b). The calls for this conceptual shift in the field were not without challenges. Some countered that the recovery concept was amorphous ("Is it like pornography? You can't define it but you know it when you see it?"), redundant ("We're already recovery oriented."), faddish ("a flavor of the month"), impractical ("No one will fund long-term recovery support."), and dangerous ("Recovery is a political Trojan horse aimed at de-professionalizing, delegitimizing, and defunding science-based treatment and harm reduction services."). Such were the challenges that faced early ARM/ROSC pilot settings (e.g., the State of Connecticut and the City of Philadelphia) and recovery-focused policy shifts within the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment and the White House Office of National Drug Control Policy.

Defining Recovery and Recovery-oriented Practice

The emergence of recovery as a new (or renewed) organizing framework for addiction treatment and the larger alcohol and other drugs policy arena sparked efforts to reach a consensus definition of recovery (Betty Ford Institute Consensus Panel, 2007), develop recovery-oriented practice

guidelines (Abrahams et al., 2012; Tondora et al., 2008), and forge a recovery-focused research agenda (Laudet, Flaherty, & Langer, 2009) that could collectively guide the future design of addiction treatment and peer recovery support services. These efforts, led by addiction professionals and people in recovery, point to a future of more person- and family-centered care and the increased involvement of addiction professionals in pre-treatment and post-(acute) treatment stages of addiction recovery. They also point to a future in which addiction professionals will be working in an ever-expanding variety of service settings and providing an expanded menu of clinical and non-clinical recovery support services. They portend a future in which addiction treatment and addiction recovery are inseparable and in which the physical, psychological, and social barriers separating the treatment institution from indigenous recovery supports in the community no longer exist (a move toward "treatment without walls"). That redesign process is already underway—pushed by recovery advocates, visionary professionals, and the cumulative findings of scientific research.

A Time for Activism

NAADAC's founding generation spent their lives widening the doorways of entry into addiction recovery. They fought to create a treatment system and a new profession (addiction counseling) to achieve that vision. The present call for increased recovery orientation within the field is in many ways a call to renew that founding vision. Many things diverted this recovery focus over the years. There were days when addiction counselors found themselves working in systems that seemed to care more about progress notes than the real progress of those being served. Yes, at times it seemed like the "new profession" would, in its worship of regulatory compliance, drown itself in a sea of paper. There were days when addiction counselors found themselves in systems that seemed more preoccupied with money management than recovery management. Yes, fixations on funding and profit have sometimes obscured the ultimate goal such resources were to serve. And yes, there were times preoccupations with our own professional status also served as a distraction from our founding recovery vision. But addiction counselors and NAADAC have always found ways to renew this vision and add our voices to those of our founders who challenged us to keep our eyes on the ultimate prize of this profession: the long-term recovery of individuals, families, and communities.

Addiction treatment as a cultural institution (as well as the role of the addictions professional) remains on probationary status within the United States and other countries of the world. The future of the field is by no means assured. It is our contention that the fate of the field will rest upon the degree of optimism—or pessimism—in which addiction recovery is viewed by the larger culture. In a culture awash with media coverage of celebrities constantly recycling in and out of "rehab," it is our voices that must help convey two messages: 1) long-term recovery is a reality in the lives of millions of individuals and families, and 2) professionally directed addiction treatment can be a critical adjunct in recovery initiation, recovery maintenance, and enhancement of quality of personal and family life in long-term recovery. Our charge is to now renew, and never again lose, this recovery vision. In the midst of all manner of health reform and service integration initiatives, that vision cannot be lost. Recovery is not a new innovation, nor is it a passing fad. It is the very soul of our profession.

About the Authors: William White is Emeritus Senior Research Consultant at Chestnut Health Systems. Cynthia Moreno Tuohy is Executive Director of NAADAC: The Association for Addiction Professionals.

References

Abrahams, I. A., Ali, O., Davidson, L., Evans, A. C., King, J., Poplawski, P., & White, W. (2012). *Practice guidelines for recovery and resilience oriented treatment*. Philadelphia: Philadelphia Department of Behavioral Health.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. doi:10.1016/j.jsat.2007.06.001

Dennis, M. L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery, 6*(2), 11-23.

Laudet, A., Flaherty, M., & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. doi:10.1001/jama.284.13.1689

Morgan, O. J. (1994). Extended length of sobriety: The missing variable. *Alcoholism Treatment Quarterly*, *12*(1), 59-71. doi:10.1300/J020v12n01_05

Tondora, J., Heerema, R., Delphin, M, Andres-Hyman, R. O'Connell, M.J., & Davidson, L. (2008). *Practice guidelines for recovery-oriented care for mental health and substance use conditions* (2nd ed.). New Haven, CT: Yale University Program for Recovery and Community Health.

White, W. L. (2001). The new recovery advocacy movement: A call to service. *Counselor, 2*(6), 64-67.

White, W. L. (2004). Recovery: The next frontier. *Counselor*, *5*(1), 18-21.

White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 3-15. doi:10.1300/J020v23n01_02

White, W. L. (2008a). *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. L. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. L., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-129. doi:10.1300/J020v20n03_06



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. & Tuohy, C.M. (2013) Recovery-oriented practice and the addictions professional: A systems perspective. *Advances in Addiction and Recovery* (NAADAC), Summer Issue, pp. 22-23. Posted at www.williamwhitepapers.com

Commentary
Recovery-oriented Practice and the Addictions Professional: A Systems Perspective

William L. White, MA and Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP

Modern addiction treatment as a system of care emerged in the early 1970s. This birthing process was followed by sustained and turbulent processes of professionalization, commercialization, and bureaucratization. New specialized addiction treatment programs were a godsend for people with alcohol and other drug problems and their families who in earlier years faced few if any resources, contempt from mainstream helping professionals, and all too often, harmful interventions masked as help. Today, hundreds of thousands of people in long-term recovery owe their lives to modern addiction treatment. So why in the past decade have we witnessed repeated calls from people in recovery and from long-tenured addiction professionals for greater recovery orientation in addiction treatment? Aren't addiction treatment and addiction counseling already recovery-oriented? In this brief essay, we will offer some historical perspectives and systems performance data to answer these questions.

Lost Connection to Recovery

There are remarkable milestones in the rise of a national infrastructure of addiction treatment, each worthy of a detailed recounting: discovery of replicable models of addiction treatment, expansion of public and private funding for addiction treatment, explosive growth of community-based treatment programs, development of program accreditation and counselor certification standards, birth of professional associations and addiction studies programs, and increased rigor addiction research, to name just a few. Yet, by the mid-1990s, as addiction treatment episodes became ever-briefer, there were warning voices suggesting that something important was being lost in the professionalization and industrialization of addiction treatment. One could hear at national conferences and read in the field's professional journals fears that addiction treatment was becoming disconnected from the larger and more enduring process of addiction recovery and that recovery initiation in institutional settings was disconnected from processes of recovery maintenance within natural community environments (Elise, 1999;

Morgan, 1994; White, 2004). A growing recovery advocacy movement also challenged that an addiction treatment field that once viewed itself as an adjunct to recovery was now viewing recovery as an adjunct (afterthought) to itself (White, 2001).

Key System Performance Measure

The opening decade of the 21st century witnessed two additional shifts that exerted a profound influence on addiction treatment. The first was the refined conceptualization of addiction as a chronic condition (McLellan, Lewis, O'Brien, & Kleber, 2000) and discussions of the implications of such an understanding to clinical practices in addiction treatment (Dennis & Scott, 2007; White, Boyle, & Loveland, 2002). The second shift involved an intensified analysis of what addiction treatment was and was not achieving as a system of care. Critiques of key system performance measures (e.g., White, 2008a) concluded that there were major problems with addiction treatment in such key areas as 1) attraction and access (only 10% of those with a substance use disorder enter treatment each year), 2) engagement and retention (less than 50% successfully complete treatment, 3) clinical practices (significant gaps between clinical research and clinical practices, 4) linkages to communities of recovery (use of passive rather than assertive linkage procedures), 5) service duration (less than optimum 90 days across levels of care), 6) continuing care (only 20-36% of adolescents and adults receive post-treatment monitoring and support), 7) post-treatment substance use outcomes (more than 50% of persons leaving treatment resume substance use within year of discharge, with most occurring within 90 days of leaving treatment), and 8) treatment recycling (64% of persons entering addiction treatment have a prior treatment; 19% have 5 or more prior treatment episodes).

Recovery as an Organizing Paradigm

These processes of professional self-inventory and systems performance evaluation triggered calls to: 1) shift the field's organizing center to one focused on recovery rather than addiction pathology or clinical/social intervention, 2) extend the design of addiction treatment from one focused almost solely on acute biopsychosocial stabilization (recovery initiation) to one that encompassed support for long-term personal and family recovery (recovery maintenance and enhanced quality of life in recovery), and to 3) nest these models of sustained addiction recovery management (ARM) within larger recovery-oriented systems of care (ROSC; White, 2005, 2008a,b). The calls for this conceptual shift in the field were not without challenges. Some countered that the recovery concept was amorphous ("Is it like pornography? You can't define it but you know it when you see it?"), redundant ("We're already recovery oriented."), faddish ("a flavor of the month"), impractical ("No one will fund long-term recovery support."), and dangerous ("Recovery is a political Trojan horse aimed at de-professionalizing, delegitimizing, and defunding science-based treatment and harm reduction services."). Such were the challenges that faced early ARM/ROSC pilot settings (e.g., the State of Connecticut and the City of Philadelphia) and recovery-focused policy shifts within the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment and the White House Office of National Drug Control Policy.

Defining Recovery and Recovery-oriented Practice

The emergence of recovery as a new (or renewed) organizing framework for addiction treatment and the larger alcohol and other drugs policy arena sparked efforts to reach a consensus definition of recovery (Betty Ford Institute Consensus Panel, 2007), develop recovery-oriented practice

guidelines (Abrahams et al., 2012; Tondora et al., 2008), and forge a recovery-focused research agenda (Laudet, Flaherty, & Langer, 2009) that could collectively guide the future design of addiction treatment and peer recovery support services. These efforts, led by addiction professionals and people in recovery, point to a future of more person- and family-centered care and the increased involvement of addiction professionals in pre-treatment and post-(acute) treatment stages of addiction recovery. They also point to a future in which addiction professionals will be working in an ever-expanding variety of service settings and providing an expanded menu of clinical and non-clinical recovery support services. They portend a future in which addiction treatment and addiction recovery are inseparable and in which the physical, psychological, and social barriers separating the treatment institution from indigenous recovery supports in the community no longer exist (a move toward "treatment without walls"). That redesign process is already underway—pushed by recovery advocates, visionary professionals, and the cumulative findings of scientific research.

A Time for Activism

NAADAC's founding generation spent their lives widening the doorways of entry into addiction recovery. They fought to create a treatment system and a new profession (addiction counseling) to achieve that vision. The present call for increased recovery orientation within the field is in many ways a call to renew that founding vision. Many things diverted this recovery focus over the years. There were days when addiction counselors found themselves working in systems that seemed to care more about progress notes than the real progress of those being served. Yes, at times it seemed like the "new profession" would, in its worship of regulatory compliance, drown itself in a sea of paper. There were days when addiction counselors found themselves in systems that seemed more preoccupied with money management than recovery management. Yes, fixations on funding and profit have sometimes obscured the ultimate goal such resources were to serve. And yes, there were times preoccupations with our own professional status also served as a distraction from our founding recovery vision. But addiction counselors and NAADAC have always found ways to renew this vision and add our voices to those of our founders who challenged us to keep our eyes on the ultimate prize of this profession: the long-term recovery of individuals, families, and communities.

Addiction treatment as a cultural institution (as well as the role of the addictions professional) remains on probationary status within the United States and other countries of the world. The future of the field is by no means assured. It is our contention that the fate of the field will rest upon the degree of optimism—or pessimism—in which addiction recovery is viewed by the larger culture. In a culture awash with media coverage of celebrities constantly recycling in and out of "rehab," it is our voices that must help convey two messages: 1) long-term recovery is a reality in the lives of millions of individuals and families, and 2) professionally directed addiction treatment can be a critical adjunct in recovery initiation, recovery maintenance, and enhancement of quality of personal and family life in long-term recovery. Our charge is to now renew, and never again lose, this recovery vision. In the midst of all manner of health reform and service integration initiatives, that vision cannot be lost. Recovery is not a new innovation, nor is it a passing fad. It is the very soul of our profession.

About the Authors: William White is Emeritus Senior Research Consultant at Chestnut Health Systems. Cynthia Moreno Tuohy is Executive Director of NAADAC: The Association for Addiction Professionals.

References

Abrahams, I. A., Ali, O., Davidson, L., Evans, A. C., King, J., Poplawski, P., & White, W. (2012). *Practice guidelines for recovery and resilience oriented treatment*. Philadelphia: Philadelphia Department of Behavioral Health.

Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. doi:10.1016/j.jsat.2007.06.001

Dennis, M. L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

Elise, D. (1999). Recovering recovery. *Journal of Ministry in Addiction and Recovery, 6*(2), 11-23.

Laudet, A., Flaherty, M., & Langer, D. (2009). *Building the science of recovery*. Pittsburgh, PA: Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. doi:10.1001/jama.284.13.1689

Morgan, O. J. (1994). Extended length of sobriety: The missing variable. *Alcoholism Treatment Quarterly*, *12*(1), 59-71. doi:10.1300/J020v12n01_05

Tondora, J., Heerema, R., Delphin, M, Andres-Hyman, R. O'Connell, M.J., & Davidson, L. (2008). *Practice guidelines for recovery-oriented care for mental health and substance use conditions* (2nd ed.). New Haven, CT: Yale University Program for Recovery and Community Health.

White, W. L. (2001). The new recovery advocacy movement: A call to service. *Counselor, 2*(6), 64-67.

White, W. L. (2004). Recovery: The next frontier. *Counselor*, *5*(1), 18-21.

White, W. L. (2005). Recovery: Its history and renaissance as an organizing construct concerning alcohol and other drug problems. *Alcoholism Treatment Quarterly, 23*(1), 3-15. doi:10.1300/J020v23n01_02

White, W. L. (2008a). *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. L. (2008b). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000. doi:10.1080/10826080802297518

White, W. L., Boyle, M., & Loveland, D. (2002). Alcoholism/addiction as a chronic disease: From rhetoric to clinical reality. *Alcoholism Treatment Quarterly*, *20*(3/4), 107-129. doi:10.1300/J020v20n03_06

The Recovery Agenda: The Shared Role of Peers and Professionals

William L. White, MA,[1]
Arthur C. Evans, Jr., PhD[2]

ABSTRACT

The alcohol and other drug (AOD) problems arena is extending its organizing center from knowledge drawn from the study of addiction-related pathologies and clinical and social interventions to knowledge drawn from the lived experience of long-term addiction recovery. A distinctive element within this shift is the increased use of non-clinical, peer recovery support services as an adjunct or alternative to specialized, professionally directed addiction treatment. This paper reviews the context of this shift, notes the evolution from competing to integrated service models, and outlines a decade of experience integrating peer recovery support services within the City of Philadelphia's behavioral healthcare system. Integrated models of peer-professional addiction recovery support have the potential of capitalizing on the respective strengths of clinical and environmental interventions into severe AOD problems.

Key Words: Addiction, recovery management, recovery-oriented systems of care, recovery support services, recovery community institutions

Recommended Citation: White WL, Evans AC. The recovery agenda: the shared role of peers and professionals. *Public Health Reviews*. 2014;35: epub ahead of print.

INTRODUCTION

Recovery is emerging as a new organizing construct within the alcohol and other drug (AOD) problems arena in the United States[1,2] and the United Kingdom.[3,4] There is growing consensus that policies based on research of drug-related pathologies and evaluative studies of clinical and social interventions can be substantially enriched by drawing lessons from the lived

[1] Chestnut Health Systems, Punta Gorda, FL, USA.
[2] Philadelphia Department of Behavioral Health and Developmental disAbility Services, Philadelphia, PA, USA.

Corresponding Author Contact Information: William White at bwhite@chestnut.org; 3329 Sunset Key Circle, # 203, Punta Gorda, FL 33955, USA.

solutions to these problems at personal, family, neighborhood, and community levels. Reflecting a parallel shift from pathogenic (disease) to salugenic (wellness) approaches in medicine, psychology, and criminology,[5,6] the emergence of a recovery paradigm is also being influenced by the growth and diversification of recovery mutual aid societies and new recovery support institutions (e.g., recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries), the emergence of an ecumenical culture of recovery embracing secular, spiritual, and religious pathways of recovery, and the political mobilization of individuals and families in recovery via US- and UK-based recovery advocacy movements.[7-9] Also influential have been the reconceptualization of severe AOD problems as chronic disorders[10,11] and accompanying calls to shift acute and palliative care models of addiction treatment to models of assertive and sustained recovery management (RM) nested within larger recovery-oriented systems of care (ROSC).[12,13] The quickening pace of service integration initiatives under the influence of unfolding healthcare reforms and suggestions that recovery might serve as a conceptual bridge for integrating mental health, addiction treatment, and primary healthcare have also added impetus toward a recovery policy agenda.[14-16]

The increasing prominence of recovery as an organizing construct is reflected in national AOD policy and funding initiatives,[17] multi-national efforts to define recovery,[18-20] state and local RM and ROSC experiments,[21] and increasing calls for a recovery research agenda that can guide the transformation of traditional models of intervention toward the RM and ROSC visions.[22] This emerging recovery agenda is being further influenced by advocacy to integrate person-centered clinical models of intervention with population-centered public health models of intervention across the dichotomized worlds of abstinence and harm reduction.[23-25] RM and ROSC implementation has progressed for nearly a decade in selected states and cities, but remains in most areas a nascent movement whose promises have yet to be tested in diverse geographical, cultural and political contexts.

A central component of RM and ROSC initiatives has been the inclusion of non-clinical, most often peer-based, recovery support services across the stages of long-term recovery.[26-28] The purpose of this paper is to review the emergence of peer recovery support services as a more visible component of community responses to AOD problems, describe how professional and peer services are being integrated within the City of Philadelphia's behavioral health systems transformation process, and highlight lessons learned from the Philadelphia experience.

DISCUSSION

Professional and Peer Models of Addiction Recovery Support

Support for the resolution of AOD problems often involves the sequential mobilization of intrapersonal resources; family, extended family, and social network resources; generalist helping resources within the community; and for the most severe and complex AOD problems, specialized addiction recovery mutual aid and/or professional treatment resources. The relationship between recovery mutual aid and professional treatment organizations has vacillated between periods of tension, separation, competition, and conflict and periods of reconciliation, reciprocal linkage, and experiments in collaboration and integration.[29] People recovering from substance use disorders (SUDs) played prominent roles in the rise of modern addiction treatment, once making up nearly 70 percent of the addiction treatment workforce. Such representation has since dropped to approximately 30 percent following more than four decades of professionalization within the addiction counseling and addiction medicine workforce.[28]

The current growth of recovery support services (RSS) and related programs (e.g., alumni services, volunteer programs) marks, in part, a visible return of people in recovery into the addiction treatment milieu. RSS represent a new category of specialized resources—not treatment and not purely mutual aid—that link and supplement traditional recovery mutual aid and addiction treatment. RSS have gained prominence in the US due to their promotion and funding through the Center for Substance Abuse Treatment's Recovery Community Services Program (since 1998) and Access to Recovery program (since 2004).[30] Their growth also reflects the broader integration of people credentialed by experience into helping roles within multiple service sectors (e.g., public health, primary medicine, mental health, child welfare).[31-33]

The term *recovery support services* sometimes refers to the whole spectrum of services that can support addiction recovery, but is most often applied to nonclinical services—supports beyond the arenas of clinical assessment, diagnosis, and treatment.[26,34] The term *peer recovery support services* (PRSS) explicitly refers to RSS provided by persons in personal/family recovery and who may possess additional qualities (e.g., age, gender, ethnicity, sexual orientation, combat experience, past incarceration) that enhance the process of mutual identification with the recovery support relationship. Recovery coaching, presently delivered in both peer and professional formats in the US and the UK, is a subset of RSS that are focused on mentoring individuals into the recovery process and guiding the development of a recovery-based lifestyle in the community.[28]

PRSS flow from theoretical and conceptual underpinnings (e.g., experiential knowledge, wounded healer, helper principle) that are distinct from clinical models of addiction treatment.[35-37] PRSS are delivered across the stages of pre-recovery engagement, recovery initiation and stabilization, recovery maintenance, and enhanced quality of personal/family life in long-term recovery (including efforts to break intergenerational cycles of problem transmission)—a far greater span of involvement than that seen within acute care models of addiction treatment.[28]

Where the primary unit of service within traditional addiction treatment is the individual, RSS encompasses the individual, family, social network, and community. The scope of RSS for individuals and families can include a very broad range of activities: recovery-focused outreach; assertive linkage to addiction treatment, recovery mutual aid, and other recovery community institutions; linkage to recovery-conducive housing, healthcare, child care, transportation, legal advocacy, education, employment, leisure activities; recovery mentoring/coaching (including stage-appropriate recovery education); recovery support group facilitation; post-treatment recovery checkups; and when needed, early re-intervention. Community level interventions include recovery resource mapping, recovery community mobilization and resource development, enhancement of recovery orientation within community service systems, and recovery-focused community education and advocacy.[34,38]

RSS are delivered within both paid and volunteer service models and are being delivered in a wide variety of organizational environments (including addiction treatment programs, recovery community organizations, faith-based organizations, managed behavioral healthcare organizations, allied health and human service organizations, and criminal justice organizations).[39] RSS are also being delivered in a wide variety of geographical and cultural contexts[40-43] and in both face-to-face and technology-based mediums (e.g., RSS delivered via internet and smart phones).[44] In terms of the degree of integration of RSS with addiction treatment, RSS may serve as an adjunct or alternative to addiction treatment and other community recovery support systems. RSS are being provided in the context of addiction treatment in sequential models (professional care followed by RSS), parallel models (professional care and RSS provided simultaneously by the same or different organizations), and integrated models (treatment services and RSS provided by the same organization or highly coordinated multiagency teams).

Early research reviews on RSS[27,28] acknowledge the paucity of research on the effects of RSS but note promising early outcomes related to the role of recovery residences and school-based RSS in elevating recovery and related outcomes.[45,46] These reviews and related studies also note the value

of particular RSS components such as use of peers in recovery to promote a peer help culture within addiction treatment units, recovery coaching, outreach and engagement, assertive linkage to recovery mutual aid and post-treatment recovery checkups,[33,47,48] as well as the value and cost effectiveness of recovery coaching within particular service contexts.[33,49] Formal evaluations of federal- and state-funded RSS also appear promising,[50] with the State of Connecticut reporting dramatic reductions in costs by using RSS as an alternative to recycling individuals with high problem severity and low recovery capital through expensive episodes of acute detoxification and brief stabilization without measurable long-term recovery outcomes. The addition of RSS allowed the State of Connecticut to break this pattern, enhance recovery outcomes, and free up financial and human resources to serve a larger number of individuals and families.[21]

The Philadelphia Experience with Professional/Peer RSS Integration

RSS in Philadelphia are rooted in a recovery-focused behavioral health systems transformation process that began in 2005.[51] Philadelphia has been involved in pioneering work in the treatment of addiction for more than a century.[29,52] In 2005, new behavioral health leadership challenged local stakeholders to draw upon that deep tradition to forge a more recovery-focused, person-centered system of care that could serve as a model for the country. The impetus for change was a series of town meetings and focus groups on the state of behavioral healthcare. These meetings generated consensus that acute and palliative care approaches to addiction treatment needed to be refocused toward sustained recovery management and expansion of the City's indigenous recovery support resources. This became a shared vision for both addiction treatment and mental health services, and PRSS became a central element within the transformation strategy led by the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). The transformation process challenged existing status hierarchies, expanded and reallocated financial resources, significantly broadened the spectrum of provider organizations and helper roles and required substantial and sustained education, training and technical assistance that continue to the present. The challenges of transformation and the change facilitation strategies employed have been detailed in an earlier report.[51]

DBHIDS created an infrastructure through which PRSS could be designed, implemented, and evaluated. That infrastructure included creation of a DBHIDS Recovery Advisory Council, increased recovery representation within DBHIDS staff and professional policy committees, and the design and delivery of a Recovery Foundations Training for multiple stakeholders

within Philadelphia's behavioral healthcare system (83 workshops, 2,490 participants). A DBHIDS transformation blueprint and Office of Addiction Services (OAS) strategic plan, developed with intense and sustained involvement of numerous community stakeholders, led to a sustained partnership between DBHIDS and the Pennsylvania Recovery Organization - Achieving Community Together (PRO-ACT)—the leading local recovery advocacy organization, the opening of Philadelphia's first recovery community center, and the subsequent expansion of PRSS. To date (2008-2013), more than 5,400 individuals have been provided PRSS through the recovery community center. Evaluations of the effects of the more than 39,000 hours of PRSS delivered through the recovery community center reveal enhanced abstinence outcomes as well as increases in employment, educational involvement income, housing stability and parental custody of children. In addition to providing system-wide and program-level guidance on service design, peers have been used to conduct street outreach, provide support during treatment, solicit feedback from clients following treatment on the relative quality of their treatment experience, and provide sustained post-treatment monitoring and support.

PRSS were nested within larger efforts to culturally mobilize diverse communities of recovery for service and advocacy. Such efforts were guided by imbedding recovery prevalence questions within existing community health surveys and mapping recovery support resources by city census tracts. Mobilization activities between 2005 and 2013 included hosting national speakers to address local communities of recovery about recovery advocacy and peer recovery support initiatives, a 12-week peer leadership academy (59 graduates in 2011-2012), 34 Certified Peer Specialist (peers in paid service roles) trainings (611 trainees), 92 recovery storytelling workshops (1,532 trainees), 31 peer group facilitator trainings (519 trainees), and 285 Taking Recovery to the Streets presentations to individuals in treatment provided by 59 trained peers. Through support of a federal Access to Recovery grant, DBHIDS expanded recovery support services through a network of 52 community and faith-based service providers with service coordination provided by 22 Peer Recovery Specialists. More than 8,500 individuals were served through this initiative between 2011 and 2013. Since 2005 DBHIDS has also sponsored two major professional/peer recovery conferences, co-sponsored Amends in Action events (involvement of people in recovery in community service projects), and co-hosted an annual public recovery celebration event (with more than 18,000 participants in 2012). Other efforts to increase the visibility of recovery in Philadelphia included support for recovery-focused sports, music, radio, television, and journalism activities, and creating recovery murals as part of Philadelphia's Mural Arts Program.

DBHIDS also took strategic steps to increase the recovery orientation of its treatment providers. These steps included encouraging treatment programs to develop consumer councils, developing and disseminating recovery-focused practice guidelines, providing enhanced service reimbursement rates for achieving recovery-focused service benchmarks, and creating multiple ongoing opportunities for communication and collaboration between leaders of recovery community organizations, addiction treatment programs, and other indigenous community service programs (e.g., faith-based recovery ministries).

NET: A Peer-Professional Integration Case Study

The NorthEast Treatment Centers' (NET) development of PRSS illustrates how the transformation process influenced the culture of Philadelphia's network of addiction treatment providers. Founded in 1970, NET is a non-profit organization offering addiction, mental health, foster care, and other social services to adults, adolescents, children, and their families in Southeastern Pennsylvania and the state of Delaware. With an annual operating budget of approximately USD $59 million, Net's staff of more than 900 employees serves more than 9,000 individuals and their families each year. NET's addiction-related service menu includes intensive outpatient services (3,800+ per year), residential services (250+ per year), medically monitored inpatient detoxification (2,100+ per year), and medication-assisted treatment (500+ per year).

In response to the larger recovery-focused systems transformation process sparked by the Philadelphia DBHIDS, NET embarked on its own internal systems transformation process in December of 2005. NET's transformation process included four key steps: 1) involving all NET stakeholders in discussions about the shift toward an RM and ROSC service philosophy, 2) using training and clinical supervision to help staff and peer specialists redefine roles and service relationships, 3) merging fragmented and separate program services into an integrated continuum of care, and 4) creating a Consumer Council within each of four service delivery sites and a NET advisory board (with representation from each Consumer Council) to drive NET's organizational transformation process and the integration of PRSS.[53] The Consumer Councils meet weekly, host a monthly recovery recognition day and annual recovery celebration and awards dinner, and publish newsletters (e.g., the bi-monthly *NET-Steps*) that are disseminated to all NET consumers and staff. The Councils also oversee the NET volunteer program, conduct client community integration workshops, oversee the consumer speaker's bureau, co-staff four recovery community

centers (consumer-operated drop-in centers that provide pre-treatment, in-treatment and post-treatment social support, emergency housing, treatment referral, medical referral, free clothing, job coaching, life skills training, and a computer lab), and conduct their own fundraising activities.

Philadelphia's recovery-focused transformation process provided an opportunity for NET to significantly increase its peer recovery specialist positions. Currently, 21 peer specialists (19 full time equivalents) are employed at NET—funded out of increased revenues NET receives from the enhanced retention and service participation rates that were a direct result of PRSS.[54] NET's paid PRSS positions are supplemented by a cadre of peer volunteers called peer mentors drawn from current and former NET service consumers.

Peer specialists and volunteer peer mentors collectively perform multiple functions at NET. They conduct street outreach and link people in need to treatment and recovery mutual aid resources, greet and orient all new NET clients and their families, offer daily encouragement for participation in treatment and recovery support activities, mediate conflict between staff and clients, and make face-to-face or telephonic contact with any client who misses a service appointment. They co-facilitate (with professional staff) recovery planning groups and facilitate recovery support groups.

RECOMMENDATIONS

Based on the Philadelphia experience integrating PRSS with professional-directed addiction treatment, we would offer the following observations and recommendations to others embarking on similar efforts.

Potential for Successful Peer-Professional Integration. PRSS can be successfully integrated with professional models of care (e.g., blended and sequenced in ways that potentially magnify the catalytic potency of each). This can occur at all levels of behavioral healthcare systems, but such integration requires planning, education, and support for peers and professionals as well as education of the larger community about the role and value of PRSS.

Models of Implementation. PRSS are being added to behavioral health service systems in three sometimes sequential patterns: as an encapsulated appendage/adjunct to professional services, as part of the transformation of a particular system component, or integrated throughout a systems-wide transformation process.[51] It is our experience that the third of these choices is the far superior option. The failure to provide such integration can inadvertently lead to competition, conflict, and disaffection among both peers and professionals.

Structure for Integrating PRSS. The design and delivery of PRSS are marked by different theoretical foundations, service elements, service delivery environments, and more nuanced ethical guidelines and cultural etiquette governing service relationships than those that have traditionally guided professionally directed addiction treatment.[28] As a result, PRSS require different approaches to recruitment, selection, orientation/training, and supervision than those used for professional staff. Care must be taken in the integration process not to de-professionalize clinical services or professionalize peer support relationships. To effectively guide ROSC transformation and PRSS integration, we recommend use of a task force or advisory group that contains peer, professional, and broader community representation as well as connection to expertise within other communities that have successfully implemented PRSS.

Authenticity of Recovery Representation. Service consumers and their families as well as representatives from local communities of recovery can and should play significant roles in decision-making at all levels of the behavioral healthcare system, including the design, delivery, and evaluation of day-to-day recovery support activities. When involving people in recovery within ROSC and PRSS planning processes and recruiting PRSS specialists in staff or volunteer roles, we recommend cultivating to the extent possible a diversity of recovery representation across pathways of recovery, family as well as personal recovery representation, people in different stages of recovery, and representation across the boundaries of age, gender, and culture. It is also important to assure authenticity of recovery voices, e.g., avoiding potential problems of double agentry by selecting individuals to represent the recovery experience who do not have other personal, professional, or institutional conflicts of interest.

Balance of PRSS Functions. PRSS involve three linked functions: 1) supporting personal and family health across the stages of long-term recovery, 2) expanding community recovery capital by helping create the physical, psychological, and social space in the community within which recovery can flourish, and 3) advocating local, state, and national policies that promote health and full community reintegration of individuals and families in recovery. Achieving a balance of focus across these three arenas of action moves PRSS beyond traditional clinical models of intervention toward ecological models of community development and cultural renewal—what the authors have depicted as *community recovery*.[55]

PRSS and Stages of Recovery. Where the majority of traditional addiction treatment resources are allocated to recovery initiation and stabilization, PRSS have the potential of shortening addiction careers through pre-recovery identification, engagement, and recovery priming. PRSS also have

the potential for lowering treatment dropout rates and post-treatment SUD recurrence through the provision of in-treatment recovery support and post-treatment support of the transitions from recovery initiation to recovery maintenance and to enhanced quality of personal and family life in long-term recovery. The latter include family-, parental- and child-focused supports aimed at breaking intergenerational cycles of problem transmission. It is at this level that PRSS find common ground and partnership with community-level primary prevention and early intervention programs.

Critical Need for PRSS Research. The rapid implementation of PRSS in the US and UK is far ahead of the research on PRSS. Many critical questions related to PRSS remain unanswered or only partially answered, including most importantly: 1) Do PRSS enhance personal long-term recovery outcomes? 2) What are the effects of family-focused PRSS on the family and family subsystems? 3) Do recovery outcomes differ by the characteristics of who is providing the RSS (e.g., recovery versus non-recovery status) or by the organizational setting through which PRSS are delivered, e.g., treatment organization, recovery community organization, managed behavioral healthcare organization, faith-based organization? 4) What "active ingredients" of PRSS exert the greatest influence on recovery outcomes and system cost outcomes? 5) Are there particularly potent combinations and sequences of professional treatment and PRSS as measured by long-term recovery outcomes? 6) Do such effective service combinations and sequences differ across particular populations, including those who have a history of consuming inordinate proportions of system resources without measureable recovery outcomes? 7) Can PRSS saturation alter problem prevalence and recovery prevalence at a community level?

PRSS Financing. Peer recovery support services are being financed through a variety of mechanisms, including federal and state grants, public and private fee-for-service contracts, and indirect financing through increased income from improved rates of recruitment, engagement, and retention (at a program level) and reduced rates of recidivism in acute levels of care (at a systems or payor level). We recommend that PRSS delivery sites cultivate a balanced payor mix and a safety net of peer volunteers to assure sustainability of recovery support.

Preventing Potential Iatrogenic Effects of PRSS. Given the long record of harm in the name of help within the history of clinical and social interventions into AOD problems,[56,57] it is incumbent on behavioral health leaders to ask whether any inadvertent injuries could flow from the implementation of PRSS. In our experience with PRSS over the past decade in Philadelphia, such injuries could most likely occur in three areas. The first is potential exploitation and harm to peers related to excessive work demands, inadequate

compensation, and inadequate support to assure physical safety and ameliorate work-related emotional distress. The second risk involves harm to clients that could come from poor boundary management within the peer service relationship (e.g., emotional, sexual, financial exploitation). The third risk is a more subtle and prolonged harm that could come to the community by potential erosion of the volunteer service ethic within communities of recovery that could result from the proliferation of paid recovery support roles. We have tried to address the former through development of ethical guidelines and processes of complaint and redress related to PRSS[58] and to prevent the latter by emphasizing that PRSS must supplement and not replace natural recovery supports that currently exist within the community.

SUMMARY

With appropriately timed professional and peer support, people addicted to alcohol and other drugs can initiate and maintain recovery under the most extreme and adverse conditions and, through that recovery process, also help bring healing and health to their families and neighborhoods. RSS, and more specifically PRSS, are emerging as a key strategy in transforming acute care and palliative care models of addiction treatment into models of assertive recovery management that enhance the scope and quality of recovery support while building the community recovery capital that can support long-term recovery from addiction and related problems. PRSS provide a window of opportunity to integrate clinical and public health models of AOD problem resolution, but considerable care must be taken in implementing such models and evaluating such new service mechanisms to assure optimal outcomes and prevent any unforeseen consequences of this shift in service delivery design.

Acronyms List:
AOD = alcohol and other drug
DBHIDS = Department of Behavioral Health and Intellectual disAbility Services
NET = NorthEast Treatment Centers
PRSS = peer recovery support services
RM = recovery management
ROSC = recovery-oriented systems of care
RSS = recovery support services
SUD = substance use disorder

Acknowledgements: Development of this paper was supported by the Philadelphia Department of Behavioral Health and Developmental disAbility Services. Brooke Feldman assisted in collection of data on DBHIDS peer recovery support activities.

Conflicts of Interest: None declared.

REFERENCES

1. Clark HW. Recovery as an organizing concept. In: White, WL. Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment toward a Recovery-Oriented System of Care. Chicago (IL): Great Lakes Addiction Technology Transfer Center; 2007. p.7-21.
2. White WL. Recovery: old wine, flavor of the month or new organizing paradigm? Subst Use Misuse. 2008;43:1987-2000.
3. Berridge V. The rise, fall, and revival of recovery in drug policy. Lancet. 2012; 379:22-3.
4. Wardle I. Five years of recovery: December 2005 to December 2010—from challenge to orthodoxy. Drugs: Education, Prevention Policy. 2012;19:294-8.
5. Krentzman AR. Review of the application of positive psychology to substance use, addiction, and recovery research. Psychol Addict Behav. 2013;27:151-65.
6. Ronel N, Elisha E. A different perspective: introducing positive criminology. Int J Offender Ther Comp Criminol. 2011;56:305-25.
7. Humphreys K. Circles of Recovery: Self-Help Organizations for Addictions. Cambridge: Cambridge University Press; 2004.
8. White WL. The new recovery advocacy movement in America. Addiction. 2007;102:696-703.
9. White WL, Kelly JF, Roth JD. New addiction recovery support institutions: mobilizing support beyond professional addiction treatment and recovery mutual aid. J Groups Addict Recover. 2012;7:297-313.
10. Dennis ML, Scott CK. Managing addiction as a chronic condition. Addict Sci Clin Pract. 2007;4:45-55.
11. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000;284:1689-95.
12. Kelly JF, White WL. Addiction Recovery Management: Theory, Science and Practice. New York (NY): Springer Science; 2011.
13. White WL. 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; 2008.
14. Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. Health Aff. 2011;30:1402-10.
15. Davidson L, White W. The concept of recovery as an organizing principle for integrating mental health and addiction services. J Behav Health Serv Res. 2007;34:109-20.
16. Gagne CA, White W, Anthony WA. Recovery: a common vision for the fields of mental health and addictions. *Psychiatr Rehabil J. 2007;32:32-7.*
17. Center for Substance Abuse Treatment (CSAT). National Summit on Recovery: conference report. DHHS Publication No. (SMA) 07-4276. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2007.

18. Betty Ford Institute Consensus Panel. What is recovery? A working definition from the Betty Ford Institute. J Subst Abuse Treat. 2007;33:221-8.
19. Scottish Government. The road to recovery: a new approach to tackling Scotland's drug problem. Edinburgh: Scottish Government; 2008.
20. United Kingdom Drug Policy Commission. A consensus definition of recovery. 2008. Available from URL: http://www.ukdpc.org.uk/resources/A%20Vision%20of%20Recovery.pdf (Accessed 24 June 2010).
21. Kirk T. Connecticut's journey to a statewide recovery-oriented health-care system: Strategies, successes and challenges. In: Kelly JF, White WL, (editors). Addiction Recovery Management: Theory, Science and Practice. New York (NY): Springer Science; 2011. p.209-34.
22. Laudet A, Flaherty M, Langer D. Building the science of recovery. Pittsburgh (PA): Institute for Research, Education and Training and Northeast Addiction Technology Transfer Center; 2009.
23. Hunt N. Recovery and harm reduction: time for a shared, development-oriented, programmatic approach? In: Pates R, Riley D, (editors). Harm Reduction in Substance Use and High-Risk Behaviors. Chichester: Wiley-Blackwell; 2012.
24. Kellogg SH. On "gradualism" and the building of the harm reduction—abstinence continuum. J Subst Abuse Treat. 2003;25:241-7.
25. White WL, Mojer-Torres L. Recovery-oriented methadone maintenance. Chicago (IL): Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services and Northeast Addiction Technology Transfer Center; 2010.
26. Kaplan L. The role of recovery support services in recovery-oriented systems of care. DHHS Publication No. (SMA) 08-4315. Rockville (MD): Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration; 2008.
27. Laudet AB, Humphreys K. Promoting recovery in an evolving policy context: what do we know and what do we need to know about recovery support services? J Subst Abuse Treat. 2013;45:126-33.
28. White WL. Peer-based addiction recovery support: history, theory, practice, and scientific evaluation. Chicago (IL): Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual disAbility Services; 2009.
29. White WL. Slaying the dragon: the history of addiction treatment and recovery in America. Bloomington (IL): Chestnut Health Systems, 1998.
30. Kaplan L, Nugent C, Baker M, Clark HW, Veysey BM. Introduction: the Recovery Community Services Program. Alcohol Treat Q. 2010;28:244-55.
31. Brownstein JN, Bone LR, Dennison C, Hill MN, Kim M, Levine DM. Community health workers as interventionists in the prevention and control of heart disease and stroke. Am J Prev Med. 2005;29:128-33.
32. Mowbray CT, Moxley DP, Jasper CA, Howell LL. Consumers as Providers in Psychiatric Rehabilitation. Columbia (MD): International Association of Psychosocial Rehabilitation Services (IAPSRS); 1997.

33. Ryan J, Choi S, Hong JS, Hernandez P, Larrison CR. Recovery coaches and substance exposed births: an experiment in child welfare. Child Abuse Negl. 2008;32:1072-9.
34. Center for Substance Abuse Treatment. What are peer recovery support services? HHS Publication No. (SMA) 09-4454. Rockville (MD): Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services; 2009.
35. Borkman T. Experiential knowledge: a new concept for the analysis of self-help groups. Soc Serv Rev. 1976;50:445-56.
36. Jackson SW. The wounded healer. Bull Hist Med. 2001;75:1-36.
37. Riessman F. The "helper" therapy principle. Soc Work. 1965;April:27-32.
38. Valentine P. Peer-based recovery support services within a recovery community organization: the CCAR experience. In: Kelly JF, White WL, (editors). Addiction Recovery Management: Theory, Science and Practice. New York (NY): Springer Science; 2011. p.259-80.
39. White W, Humphreys K, Bourgeois M, Chiapella P, Evans A, et al. The status and future of addiction recovery support services in the United States: report of the BFI/UCLA Consensus Conference on Recovery Support Services; 2013.
40. Achara-Abrahams I, Evans AC, Ortiz J, Lopez Villegaz D, O'Dell J, et al. Recovery management and African Americans: a report from the field. Alcohol Treat Q. 2012;30:263-92.
41. Evans AC, Achara I, Lamb R, White W. Ethnic-specific support systems as a method for sustaining long-term addiction recovery. J Groups Addict Recover. 2012;7:171-88.
42. Moore S, Coyhis D. The multicultural wellbriety peer recovery support program: two decades of community-based experience. Alcohol Treat Q. 2010;28:273-92.
43. Veysey BN, Grasmere J, Andersen R. Supporting peer recovery in rural New England: the RECOVER Project, Franklin County, MA. Alcohol Treat Q. 2010;28:306-25.
44. Klein AA, Slaymaker VJ, Dugosh KL, McKay JR. Computerized continuing care support for alcohol and drug dependence: a preliminary analysis of usage and outcomes. J Subst Abuse Treat. 2012;37:435-42.
45. Cleveland HH, Harris KS, Baker AK, Herbert R, Dean LR. Characteristics of a collegiate recovery community: maintaining recovery in an abstinence-hostile environment. J Subst Abuse Treat. 2007;33:13-23.
46. Jason LA, Mericle AA, Polcin DL, White WL, the National Association of Recovery Residences. A primer on recovery residences in the United States. Atlanta (GA): National Association of Recovery Residences; 2012.
47. Dennis ML, Scott CK. Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). Drug Alcohol Depend. 2012;121:10-17.
48. Galanter M, Castaneda R, Salamon I. Institutional self-help therapy for alcoholism: clinical outcome. Alcohol Clin Exp Res. 1987;11:424-9

49. Humphreys K, Moos R. Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. Alcohol Clin Exp Res. 2001;25:711-16.
50. Krupski A, Campbell K, Joesch JM, Lucenko BA, Roy-Byrne P. Impact of access to recovery services on alcohol/drug treatment outcomes. J Subst Abuse Treat. 2009;37:435-42.
51. Achara-Abrahams I, Evans AC, King JK. Recovery-focused behavioral health systems transformation: a framework for change and lessons learned from Philadelphia. In: Kelly JF, White WL, (editors). Addiction Recovery Management: Theory, Science and Practice. New York (NY): Springer Science; 2011. p.187-208.
52. Leonard EC. The treatment of Philadelphia inebriates. Am J Addict. 1997;6:1-10.
53. The Net Consumer Council, Evans AC, Lamb RC, Mendelovich S, Schultz CJ, White WL. The role of clients in a recovery-oriented system of addiction treatment: the birth and evolution of the NET Consumer Council. Philadelphia (PA): Philadelphia Department of Behavioral Health and Mental Retardation Services; 2007.
54. McSherry T. The recovery-focused transformation of addiction treatment: an interview with Terence McSherry. 2012. Available from URL: http://www.williamwhitepapers.com/pr/2012%20Terence%20McSherry%20Interview.pdf (Accessed 9 July 2013).
55. Evans AC, Lamb R, White WL. The community as patient: recovery-focused community mobilization in Philadelphia, 2005-2012. Alcohol Treat Q. in press.
56. Ilgen MA, Moos R. Deterioration following alcohol use disorder treatment in Project MATCH. J Stud Alcohol. 2005;66:517-25.
57. White WL, Kleber HD. Preventing harm in the name of help: a guide for addiction professionals. Counselor. 2008;9:10-17.
58. White W, the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue B. Ethical guidelines for the delivery of peer-based recovery support services. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services; 2007.

SciMedCentral

Journal of Substance Abuse & Alcoholism

Research Article

Recovery Support for Adolescents with Substance use Disorders: The Impact of Recovery Support Telephone Calls Provided by Pre-Professional Volunteers

Bryan R Garner*, Mark D Godley, Lora L Passetti, Rodney R Funk and William L White

Chestnut Health Systems, USA

***Corresponding author**

Bryan R Garner, Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761, USA, Email: brgarner@chestnut.org

Submitted: 20 December 2013

Accepted: 07 February 2014

Published: 18 February 2014

Copyright

© 2014 Garner et al.

OPEN ACCESS

Keywords

- Adolescent
- Recovery support
- Substance use
- Volunteers

Abstract

The present quasi-experiment examined the direct and indirect effects of recovery support telephone calls following adolescent substance use disorder treatment. Six-month outcome data from 202 adolescents who had received recovery support calls from primarily pre-professional (i.e., college-level social service students) volunteers was compared to 6-month outcome data from a matched comparison sample of adolescents (n = 404). Results suggested adolescents in the recovery support sample had significantly greater reductions in their recovery environment risk relative to the comparison sample (β = -.17). Path analysis also suggested that the reduction in recovery environment risk produced by recovery support calls had indirect impacts (via recovery environment risk) on reductions in social risk (β = .22), substance use (β = .23), and substance-related problems (β = .16). Finally, moderation analyses suggested the effects of recovery support calls did not differ by gender, but were significantly greater for adolescents with lower levels of treatment readiness. In addition to providing rare empirical support for the effectiveness of recovery support services, an important contribution of this study is that it provides evidence that recovery support services do not necessarily have to be "peer-based," at least in terms of the recovery support service provider having the experiential credentials of being "in recovery." If replicated, this latter finding may have particularly important implications for helping increase the recovery support workforce.

INTRODUCTION

Although research has identified effective interventions for the treatment of adolescent substance use disorders and related problems [1-4], research also has shown relapse and continued substance use are common following discharge from treatment [5-7]. These findings combined with longer-term findings with adults [8-10] have prompted increasing recognition that substance use disorders can be a chronic condition requiring long-term treatment and support similar to other chronic conditions such as mental illness, hypertension, diabetes, and congestive heart failure [11-15]. One approach to the long-term care of substance use problems that has received considerable research attention is known as continuing care (historically referred to as "aftercare"). Although reviews of the continuing care research have revealed mixed support for the effectiveness of continuing care [16-18], a recent meta-analytic review of continuing care for substance use disorders found that continuing care had a significant positive effect at both the end of the continuing care interventions (g = .19) and at follow-up (g = .27) [18].

Despite demonstrated support for the effectiveness of continuing care approaches, broader dissemination and implementation of evidence-based continuing care services within practice settings remains limited [19,20]. While additional research to more fully understand the barriers to greater

implementation of evidence-based continuing care services within real-world settings is clearly needed, cost and accessibility have been two common concerns. To decrease associated costs (e.g., travel to client homes) and increase accessibility of continuing care services, research has increasingly focused on the potential effectiveness of providing continuing care services via the telephone [21-31]. Similar to the general continuing care literature, research support for the effectiveness of telephone-based continuing care appears to be equivocal [21-23,25-28,30,31]. Thus, further research is needed to better understand factors associated with effective telephone-based continuing care.

Another approach to the long-term care of substance use disorders is "recovery support." In contrast to professionally delivered continuing care approaches, recovery support has been defined as "the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems" [32]. Recovery support via participation in secular, spiritual, or religious recovery mutual-aid societies (e.g, SMART Recovery, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Celebrate Recovery) or other recovery community institutions (e.g., recovery community centers, recovery social clubs, recovery homes, recovery schools) has a long and rich history [32]. Of particular import for those serving substance-involved adolescents is the growth of support structures specifically for youth (e.g., young people's AA and NA meetings, Teen Addiction Anonymous) and youth-led or youth-focused recovery advocacy organizations (e.g., Young People in Recovery, Transforming Youth Recovery).

Consistent with the increasing frequency of continuing care delivered via the telephone, there also has been increasing use of the telephone to deliver recovery support services. For example, as described by Valentine [33], in 2009, the Connecticut Community for Addiction Recovery (CCAR) made 36,865 outbound support calls to 1,420 recovering individuals. Particularly noteworthy is that although the equivalent of approximately $380,000 in services were provided, the actual cost to CCAR was limited primarily to costs associated with paid staff time spent recruiting, training, coordinating, and supervising volunteers. Given the minimal costs associated with providing recovery support by volunteers, this appears to be a promising approach. To date, however, examinations of the effectiveness of recovery support services via experimental tests have been limited and focused on recovery support services for adults [32,34-36].

Recovery support delivered by the groups and organizations noted above (e.g., recovery mutual aid groups, recovery social clubs, recovery homes, recovery schools) are commonly provided by other individuals who are "in recovery." As such, these types of recovery support services are often more specifically referred to as "peer-based recovery support" [32]. Although research has found service provider recovery status to have a significant positive relationship with client perceptions of credibility [37], therapeutic relationship [38], and treatment satisfaction [39], research has not generally supported service provider recovery status as being significantly associated with client substance use outcomes [40-43]. These latter findings, combined with other research supporting the use of non-professionals to address substance use disorders [44-46], has raised questions about the extent to which recovery support services could be provided effectively by non-professional individuals who do not identify as being "in recovery."

In order to help address this important question, the current paper conducted a quasi-experimental examination of the direct and indirect effects of recovery support telephone calls following adolescent substance use disorder treatment, as delivered by mostly pre-professional (i.e., college-level social service students) volunteers, the majority [75%] of whom did not identify themselves as being in recovery. We hypothesized that relative to a matched comparison sample, adolescents receiving the recovery support telephone calls would report greater post-treatment reductions in recovery environment risk, social risk, substance use, and substance-related problems. Additionally, based on prior research [47,48], we hypothesized that the impact of the recovery support telephone calls on substance use and substance-related problems would be mediated by reductions in recovery environment risk and social risk (see Figure 1). Finally, based on research that has found gender [27,49-51] and readiness to change [27,51] to be important moderators of continuing care interventions, we hypothesized that the effects of the recovery support telephone calls would be significantly greater for females and for individuals reporting lower levels of treatment readiness.

METHODS

Study context

In 2009, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (SAMHSA/CSAT) funded an innovative project called Recovery Support for Adolescents and Families (RSAF). The primary goal of this project was to provide recovery support services to adolescents and their families following episodes of outpatient or residential substance use disorder treatment. The project included four adolescent substance use disorder treatment providers located in Bloomington, IL, Fitchburg, MA, Seattle, WA, and Tucson, AZ.

Participants

Two hundred and two adolescents (94% of the 215 eligible adolescents) were recruited to participate in the project. In order to be eligible for the project, adolescents must have: a) been 13-18 years of age at the time of recruitment, b) met DSM-IV-TR diagnostic criteria for substance abuse or dependence, c) been enrolled and remained in either outpatient treatment for at least 4 sessions within 44 days from the intake session or in residential treatment for at least 2 weeks, d) resided in one of the four respective RSAF project catchment areas, and e) had telephone access either at their home or another location. Additionally, adolescents were excluded from the project if they met any of the following exclusion criteria: a) showed evidence of a psychotic or organic state of sufficient severity to interfere with understanding of project instruments, project procedures, or the informed consent process, b) were deemed an imminent danger to self or others, c) were a ward of child protective services, or d)

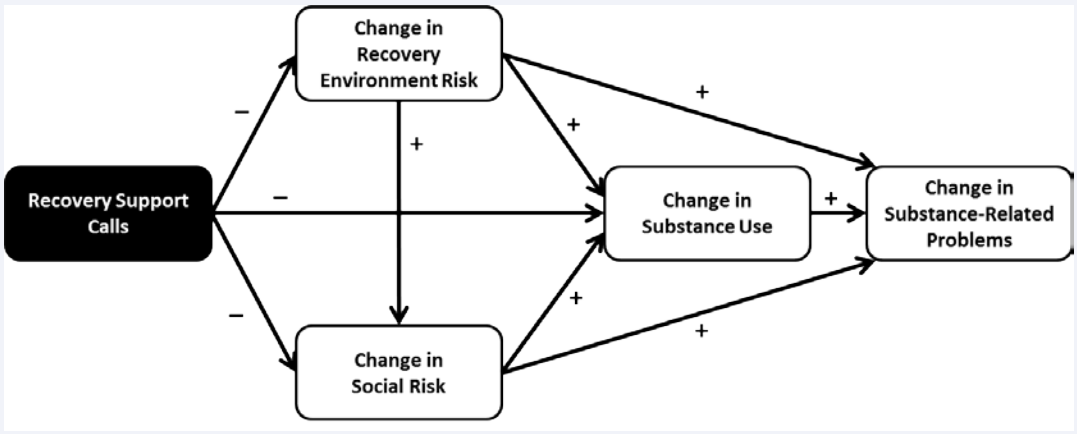


Figure 1 Hypothesixed Model.

were scheduled to enter a state juvenile justice or correctional system institution within 3 months of recruitment. All project procedures were conducted under the auspices of Chestnut Health Systems' Institutional Review Board.

Recovery support volunteers

Sixty project volunteers, who were primarily recruited from local university undergraduate and graduate social work and nursing programs, were included as part of the current study. The average volunteer age was 29 years, with approximately half (n=29) between the ages of 17 and 22. Seventy-two percent were female. Allowing for self-report of more than one race/ethnicity, the volunteers described themselves as follows: 82% Caucasian; 17% Asian; 15% Hispanic; 3% Alaska Native/American Indian; and 2% Native Hawaiian/Pacific Islander. Forty-eight percent completed some college education; 32% had a bachelor's degree; 8% had a master's degree; 5% had an associate's degree; 5% completed high school; and 2% had not finished a high school or equivalent education. Finally, the majority (77%) did not report being in recovery. All volunteers agreed to participate in background checks and in a training session on support call procedures, ethics, and confidentiality that incorporated didactic learning, role-plays using support call procedures, and listening to examples of actual telephone support sessions. In addition to documenting call information (e.g., call date, call minutes, notes), volunteers also recorded recovery support calls using a digital recorder. Both call documentation and session audio files were uploaded to a secure server via a web-based program created specifically for this project. Volunteers received weekly supervision and feedback from project coordinators based on reviews of randomly selected cases.

Procedures

Participant recruitment: Adolescents were approached about project participation during outpatient or residential substance use treatment by project staff not associated with treatment at each performance site. Parent/guardian consent was required and obtained for all assenting adolescents. All adolescents who passed inclusion and exclusion criteria and signed the informed assent with guardian consent were provided project services and retained for follow-up interviews.

Recovery support service calls: Within the first week after discharge from treatment, trained volunteers (described above) initiated recovery support service telephone calls, which incorporated concepts from two evidence-based treatments for adolescent substance use disorders: the Adolescent Community Reinforcement Approach (A-CRA) [6,52] and Assertive Continuing Care (ACC) [7,48,53]. More specifically, volunteers were trained to deliver eleven procedures (two optional). During each session, volunteers were instructed to ask about: a) significant events since the last call (i.e., completed a "check-in"); b) substance use, if any, since the last contact; c) steps adolescents recently took to stay clean and sober; d) additional ways adolescents could think of to stay clean and sober; e) the occurrence of any using thoughts and strategies for dealing with them; f) pro-recovery goals and homework to set for the next week; g) progress on goals set during the previous call; h) recovery-related events in adolescents' home communities; and i) the use of additional support services (e.g., recovery-oriented websites).The two optional procedures were referrals for further substance abuse treatment services if relapse occurred and referrals for mental health services if emotional and/or behavioral difficulties were reported. Consistent with the goals of ACC, volunteers reached out to adolescents to schedule and hold the first telephone session within two weeks of discharge from their index treatment episode. Once telephone sessions began, volunteers guided adolescents to create goals that were positive, specific, brief, and under their control to complete. Volunteers also explored potential barriers to completing homework goals to overcome practical issues, such as problems with transportation or negative mood states. Telephone callswere typically 15 minutes or less in length. Text messaging was used to remind adolescents of upcoming calls and to encourage them to answer their phones. On rare occasions, texting sessions were completed at an adolescent's request. The goal during the recovery support call phase was to complete sessions with adolescents once per week during the first 90 days after discharge. The frequency of contacts after that time varied depending on adolescents' functioning and preference. For example, a decrease in calls may have been triggered when adolescents reported an extended period of abstinence or when adolescents asked volunteers to do so, and an increase in call frequency may have been triggered by a relapse, worsening of existing problems, or the emergence of new problems.

Protocol adherence: All telephone recovery support sessions were recorded with the participant's permission. Coordinators at each site reviewed a random sample of calls for each volunteer and provided positive and corrective feedback on protocol adherence during weekly supervision meetings with volunteers. Over the course of the study, 1,742 telephone sessions were completed out of a possible 3,786, for a telephone session completion rate of 46%. For telephone protocols, this rate compares favorably to the average of 37.5% found by Godley et al. [25] and the mean of 11.5 sessions completed out of 32 planned calls completed by McKay et al [26]. An average of nine specific recovery support procedures were completed per call. In addition, homework assignments were agreed to in 94% of sessions, and 69% of homework was reported by adolescents in subsequent sessions to be completed.

Participant assessments: Baseline assessments using the Global Appraisal of Individual Needs (GAIN), [54] which is a widely used comprehensive biopsychosocial assessment that integrates research and clinical assessment into one structured interview, were conducted by trained staff with adolescents at intake to outpatient or residential treatment. The GAIN's main scales have been shown to demonstrate good internal consistency (with alphas greater than .90 on main scales, .70 on subscales) and test–retest reliability (Rhos greater than .70 on days/problem counts, kapp as greater than .60 on categorical measures) and to be highly correlated with measures of use based on timeline follow-back methods, urine tests, collateral reports, treatment records, and blind psychiatric diagnosis (Rho of .70 or more, kappa of .60 or more) [6,54-63]. Copies of the instruments, manual, publications, and documentation on the 100 plus scales in the GAIN are available at www.chestnut.org/li/gain. In addition to the baseline assessment, a follow-up version of the GAIN was completed at 3 and 6 months post-intake. Participants were compensated $30 in gift cards for the time and effort required to complete follow-up measurement interviews, as well as an additional $10 in gift cards for completing interviews within 1 week of its due date.

Creation of Quasi-Experimental comparison sample: In addition to using data collected as part of the RSAF project, data for the current study came from the GAIN 2009 Summary Analytic dataset, which is one of the largest substance use disorder treatment datasets (N = 22,548). As described in more detail below, this data set was used to create a matched comparison sample that would allow us to quasi-experimentally examine the impact of the recovery support calls. Over two-thirds of the assessments were conducted by independent investigators, funded by a wide range of organizations (e.g., SAMHSA/CSAT; National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, Robert Wood Johnson Foundation), and conducted in a variety of settings and levels of care. All data were collected as part of general clinical practice or specific research studies under their respective voluntary consent procedures, and all data were subsequently de-identified and made available for secondary analysis under the supervision of Chestnut Health Systems' Institutional Review Board.

After sub setting the GAIN Summary Analytic dataset to 6,696 adolescents similar to those in the RSAF project in terms of age, level of care, and engagement in treatment, we then created a propensity score [64,65] using the variables listed in Table 1 to predict the probability (i.e., propensity) of being in the RSAF sample. Propensity scores were created separately for adolescents treated in outpatient and residential in order maximize the ability of the propensity procedure to create a matched comparison sample. In order to emphasize the contribution of those cases more similar to the RSAF sample and de-emphasize the contributions of those cases less similar to the RSAF sample, weights were created. More specifically, the propensity score for each case was divided by the respective group mean to create an initial Weight variable (W1). Next, a second weight variable was created by dividing the N of the RSAF sample (n = 202) by the N of the GAIN Summary Analytic dataset subset (n = 5,865). The final weighting variable (W3) was then created by multiplying W1 by W2. Finally, to reduce achieving statistical significance for all analyses due to our relatively large comparison sample, we reduced the size of our matched comparison sample to 404, which provided 80% power to detect at least small effect sizes (d = .20).

Measures

Recovery environment risk: The 12-item Recovery Environment Risk Index (RERI) was used to assess the adolescent's recovery environment. RERI items focus on content breadth rather than homogeneity, and the items represent causal indicators of the construct (i.e., one's recovery environment risk is determined by the number of risk factors present). As such, strong correlations among items would not be expected, and internal consistency would not be an appropriate method of estimating reliability [66]. The summative RERI measure includes days or recency (divided by range) of support group attendance (reversed); homelessness; living with alcohol or drug use in the home; violent arguments; and physical, emotional, or sexual abuse. Higher scores indicate less involvement in support groups (e.g., Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous) and more environmental risk from alcohol/drug use in the home, fighting, and/or victimization.

Social risk: The six-item Social Risk Index (SRI) was used to assess the adolescent's social networks. Similar to RERI, because items on the SRI are causal indicators, we did not compute coefficient alpha for this heterogeneous measure. The summative SRI measure represents a sum of items indicating how many individuals the respondent "hangs out" with socially who are involved in school, training, illegal activities, substance use, or treatment or in recovery. Higher scores indicate more time with individuals in their social environment who are using alcohol/drugs, are involved in illegal activity, argue, are not in school or work, and have never been in treatment.

Substance use: The Substance Frequency Scale (SFS; alpha = .83) was used to measure frequency of adolescents' substance use. The SFS is an average percentage of days during a 90-day period that an adolescent reports each of the following: days of "any" substance use, days of heavy substance use, days of alcohol use, cannabis use, crack/cocaine use, and heroin/opioid use. The scale ranges from0to 1, with ahigher number indicating more overall reported use. The SFS has been demonstrated to be a better overall predictor of substance-related problems

Table 1: Baseline Characteristics.

Baseline Characteristics	Recovery Support Sample (N = 202)	Matched Comparison Sample (N = 404)	Effect Size
Female (%)	26%	31%	-0.13
Race			
African American	6%	12%	-0.21
Caucasian	56%	45%	0.22
Hispanic	23%	22%	0.04
Mixed/Other	14%	21%	-0.18
Age (Mean [SD])	16.0 [1.2]	15.9 [1.3]	-0.11
Single Parent	55%	51%	0.07
School			
In School	70%	81%	-0.24
Behind < 1 year	58%	57%	0.01
Expelled or Dropped out	42%	43%	-0.03
Employed[a]	19%	18%	0.01
Illegal Activity			
Any Illegal activity[b]	80%	79%	0.02
Any property crime[b]	69%	64%	0.11
Any interpersonal crime[b]	54%	52%	0.04
Any drug crime[b]	58%	57%	0.01
Delinquency Level			
None	4%	3%	0.04
Unofficial delinquency	15%	11%	0.11
Arrest/Police contact	8%	13%	-0.19
Court/Probation/Parole	34%	37%	-0.05
Correctional Institution	39%	36%	0.08
Justice Involvement			
Lifetime Justice System Involvement	80%	85%	-0.13
Current Justice System Involvement	70%	68%	0.04
In a controlled environment[a]	60%	57%	0.05
13+ days In Controlled Environment[a]	45%	40%	0.11
Intensity of Juvenile Justice System Involvement			
In detention/jail 30+ days	15%	13%	0.05
In detention/jail 14-29 days	14%	13%	0.05
On probation/parole 14+ days with 1+ drug screens	23%	27%	-0.09
Other probation/parole/ detention	13%	11%	0.06
Other Juvenile Justice status	9%	12%	-0.10
Arrest/Juvenile Justice status[b]	4%	6%	-0.07
Illegal activity[b]	22%	19%	0.07
Environment			
Any physical violence[b]	78%	73%	0.10
Weekly Alcohol Use in home[a]	28%	31%	-0.07
Weekly Drug Use in home[a]	16%	17%	-0.03
Work/School Peers Weekly Intoxication	55%	52%	0.05
Social Peers Weekly Intoxication	61%	66%	-0.10
Work/School Peers Regular Drug use	71%	70%	0.03
Social Peers Weekly Regular Drug use	80%	80%	0.00
Ever Homeless or Runaway	46%	45%	0.02
Lifetime Victimization	64%	69%	-0.10
High Severity Victimization Lifetime	48%	55%	-0.13
Victimization[a]	23%	24%	-0.02
Substance Use			
First Use under Age of 15	86%	85%	0.03
Weekly Tobacco Use[a]	71%	68%	0.06
Weekly Alcohol Use[a]	31%	27%	0.09
Weekly Marijuana Use[a]	63%	61%	0.03
Weekly Other Drug Use (not Tobacco, Alcohol or Marijuana)[a]	28%	22%	0.12
Any Lifetime Dependence	82%	79%	0.08
Any Lifetime Abuse	14%	18%	-0.11
Any Past Year Dependence	77%	75%	0.06
Any Past Year Abuse	18%	21%	-0.07
Any lifetime withdrawal symptoms	47%	49%	-0.03
Any past week withdrawal symptoms	11%	17%	-0.17
Any Prior Substance Abuse Treatment	57%	54%	0.05
Self-Perceived Substance Problem	51%	52%	-0.01
Self-Perceived Need for Treatment	90%	88%	0.06
Physical and Mental Health			
High Health Problems[a]	20%	20%	0.01
Pregnant or got someone pregnant[b]	16%	16%	0.00
Major Depressive Disorder[b]	47%	51%	-0.08
Generalized Anxiety Disorder[b]	18%	20%	-0.04
Any homicidal/suicidal thoughts[b]	33%	31%	0.04
Any Traumatic Stress Disorder[b]	36%	38%	-0.05

Conduct Disorder[b]	65%	61%	0.08
AD/HD[b]	50%	51%	-0.02
Any prior mental health treatment	60%	63%	-0.06
Sexual Activity			
Any sexual activity[a]	68%	68%	0.00
Multiple sexual partners[a]	42%	40%	0.04
Any unprotected sexual activity[a]	34%	36%	-0.03
Needle Use[a]	5%	5%	0.02
Index Substance Use Treatment episode			
Outpatient	19%	21%	-0.06
Intensive Outpatient	14%	11%	0.08
Residential	67%	67%	0.00
Length of stay in index treatment in months (Mean [SD])	2.0 [1.2]	2.4 [1.2]	0.34
Planned discharge from index treatment	82%	60%	0.49
Problem Summary[b]			
No major problems	0%	1%	-0.02
1 problem	2%	2%	0.01
2 problems	7%	10%	-0.07
3 to 12 problems	90%	88%	0.07
[a] In Past 90 days			
[b] In Past 12 months			

(e.g., withdrawal, abuse/dependence symptoms, illegal activity, and emotional problems) than individual self-report items (e.g., past-month abstinence, days of use, peak use, and recency of use), biometric measures (e.g., urine and saliva), or various combinations of these measures in both adults and adolescents [62,63]. Prior to administration of 6-month interview questions regarding adolescents' substance use, adolescents were asked if they had used any drug other than alcohol in the past week. If past week use was denied, project staff asked adolescents for a urine sample that was screened immediately on-site using the Quik Screen 5 Plus immunochromatographic assay with a one-step drug cup (www.cliawaived.com). Specimens were monitored for temperature and color and checked for adulterants using a built-in strip that tested pH, specific gravity, and level of creatinine, nitrites, bleach, and pyridiumchlorochromate. Standard cutoffs for drug metabolites were: amphetamine (1000 ng/ml), cocaine/benzoylecgonine (300 ng/ml), methamphetamine (1000 ng/ml), opiates/morphine (2000 ng/ml), and cannabis (50 ng/ml). Adolescents were told test results and then administered interview questions. If they tested positive for a drug but did not report using it in the past week, they were asked about reasons for this difference in an attempt to reconcile the conflicting information. This on-site testing procedure resulted in a relatively low false negative rate (positive on urine test; but no past month use self-reported) of 8%.

Substance-related problems: The Substance Problem Scale (SPS; alpha = .91) was used to assess problems related to substance use or substance using behavior. It is based on recency ratings (e.g., past month, 2–12 months ago, more than 12 months ago, or never) on 16 symptoms: 7 corresponding to DSM–IV criteria for dependence, 4 for abuse, 2 for substance-induced health and psychological problems, and 3 on lower severity symptoms of use (hiding use, people complaining about use, weekly use). Although associated with substance use, scores on this scale are conceptually and statistically distinct [67,68].

Treatment readiness: The Treatment Readiness Index (TRI) was used to measure adolescents' readiness for treatment. Similar to RERI and SRI, because items represent causal indicators, coefficient alpha for this heterogeneous measure was not computed. It represents a count of 9 items. Five are related to treatment motivation and include responding "yes" to the following: a) pressure to be in treatment, b) belief that treatment can help, c) belief that 1+ months of treatment are needed, d) recognition of the potential need to come back to treatment, and e) recognition of the need for support from family and friends. Four items are related to treatment resistance and include participants responding "no" to the following: a) treatment being too demanding; b) having too many responsibilities to be in treatment; c) hard to resist alcohol or other drug use where the participant lives, works, or goes to school; d) old friends may try to get the participant to use.

Analytic plan

All analyses were conducted using version 17.2 of Amos structural equation modeling software [69]. In order to control for baseline differences and address the slight skewness of the data identified as part of preliminary data examination, we used change scores (follow-up score minus intake score) for all analyses. Initial analyses, which focused on examination of the direct effects of recovery support calls on the four outcomes of primary interest, were conducted via four models that regressed each respective outcome measure on a recovery support call indicator measure (1 = recovery support sample; 0 = comparison sample). Next, we tested the hypothesized direct and indirect effects model, which was based on prior research (see Figure 1) [47,48]. Missing data were handled using the full information maximum likelihood estimation method, which has been shown to closely estimate population parameters and standard errors [70]. Several standard fit indices were used, including the Root Mean Square Error of Approximation (RMSEA), the Comparative Fit Index (CFI), and the Tucker–Lewis Index (TLI). As noted by Browne and Cudeck [71], RMSEA values of less than .05 indicate a close fit in relation to the degrees of freedom, values of .08 or less indicate a fit with reasonable errors of approximation in the population, and values greater than .10 are a poor fit. Both the CFI and TLI range from 0 to 1, with values greater than .95, indicating very good fit [72-74]. Finally, we tested the extent to which the hypothesized model was invariant (i.e., not significantly different) by gender (1 = Male; 0 = Female) and treatment readiness (1 = High Treatment Readiness; 0 = Low Treatment Readiness). High vs. low treatment readiness was based on a median split.

RESULTS

Baseline sample differences

Table 1 presents a comparison of baseline characteristics

for adolescents who received recovery support telephone calls as part of the RSAF project (n = 202) and the matched comparison sample (n = 404), adjusted for the propensity score. Overall, the two samples were well balanced, with only a few differences. Characteristics with effect sizes greater than .20 included the percentage of African American adolescents (RSAF = 6%; Comparison = 12%), percentage of Caucasian adolescents (RSAF = 56%; Comparison = 45%), percentage of adolescents in school (RSAF = 70%; Comparison = 81%), mean months of index treatment episode (RSAF = 2; Comparison = 2.4), and percentage of planned discharges from index treatment episode (RSAF = 82%; Comparison = 60%).

Direct effects of recovery support on 6-month post-discharge client change

Table 2 presents results of analyses of examining the impact of recovery support calls on adolescents' reduction in their recovery environment risk, social risk, substance use, and substance-related problems as assessed six months post-discharge from their index treatment episode. The only direct effect of the recovery support calls was on reductions in adolescents' recovery environment risk, with the adolescents in the recovery support sample having significantly greater reductions (β = -.17, $p < .001$) compared to the comparison sample. An inspection of individual items contributing to the significant improvement in RERI were items associated with increasing pro-social activities, attendance at mutual aid meetings, and decreasing days alcohol was used at home by significant others.

Indirect effects of recovery support calls on 6-month post-discharge client change

Overall, the data fit the hypothesized model very well (see Figure 2; RMSEA = .057; CFI = .995; TLI = .953). Additionally, analyses supported all but two hypothesized relationships. That is, in addition to having a direct impact on reducing adolescents' recovery environment risk (β = -.16), the recovery support calls had significant indirect impacts (via recovery environment risk) on adolescents' social risk, substance use, and substance-related problems. Again, recovery support calls did not have significant direct impacts on social risk or substance use.

Moderation analyses

Invariance analyses examining the extent to which the hypothesized relationships varied by gender did not reveal gender to significantly moderate any of the hypothesized relationships; however, analyses examining the extent to which the hypothesized relationships varied by treatment readiness did support treatment readiness as a significant moderator (see Figure 3). More specifically, the inverse relationship between recovery support and change in recovery environment risk was significantly greater for adolescents with low treatment readiness (Low Treatment Readiness = β = -.25; High Treatment Readiness = β = -.08). Additionally, the positive relationship between recovery environment risk and substance-related problems was significantly greater for adolescents with high treatment readiness than those with low treatment readiness (High Treatment Readiness = β = .25; Low Treatment Readiness = β = .02). Although not statistically significant, results also indicated a differential relationship between recovery support and substance use by level of treatment readiness (Low Treatment Readiness = β = -.04; High Treatment Readiness = β =.09).

DISCUSSION

Study reprise

The present quasi-experimental study sought to advance the limited current understanding about the effectiveness of recovery support services following adolescent substance use disorder treatment, as well as to examine the extent to which the effect

Table 2: Direct effects of recovery support on 6-month post-discharge client change.

	Recovery Environment			Social Risk			Substance Use			Substance-related Problems		
	β	SE	P=	β	SE	P=	β	SE	P=	β	SE	P=
Recovery Support Sample	-0.17	0.011	<.001	-0.05	0.585	0.301	-0.01	0.021	0.776	0.02	0.522	0.652

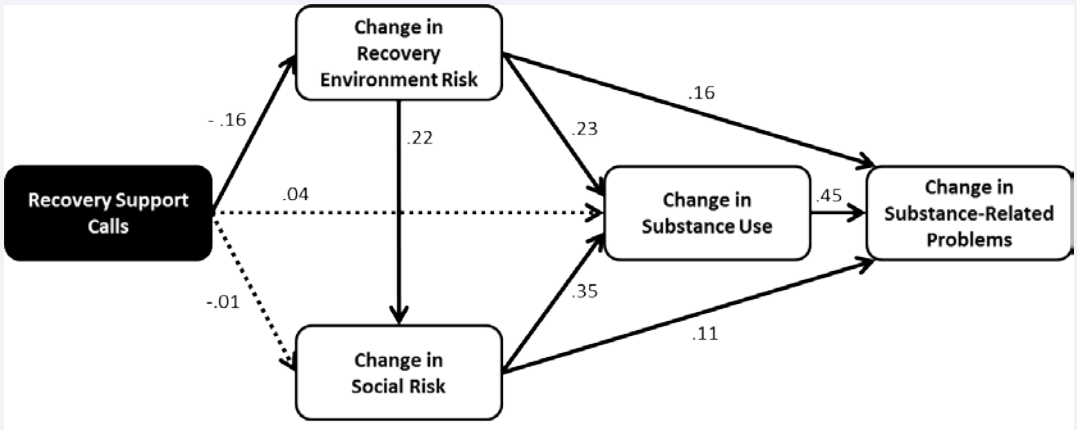


Figure 2 Results for Hypothesized Model. Solid lines are statistically significant (p< .05); Dotted lines are not statistically significant: Root Mean square Error of Approximation= .057, Comparative Fit Index= 0995; Tucker- Lewis Index= .953

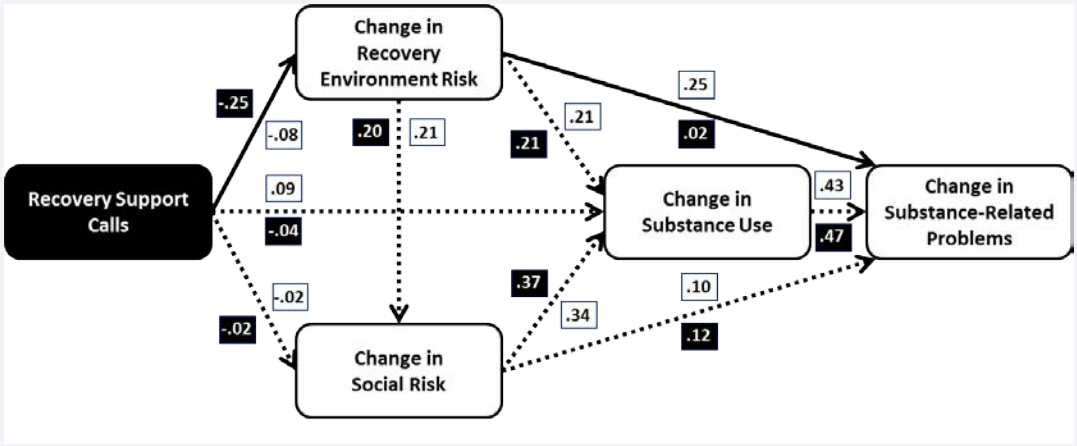


Figure 3 Treatment readliness as a moderator. Black boxes with white font indicate coefficient for adolescent with low treatment readiness; white boxes with black font indicate coefficient for adolescents with high treatment readiness. Solid lines indicate paths that differ significantly ($p < .05$) by level of treatment readiness.

of such services may differ by factors known to moderate the impact of continuing care interventions (i.e., gender, treatment readiness). As hypothesized, adolescents who received recovery support calls had significantly greater reductions in their recovery environment risk, relative to a matched comparison sample. Results from the current study did not support the recovery support calls having direct effects on post-treatment measures of improvement in social risk, substance use, or substance-related problems; however, consistent with prior research suggesting recovery environment risk as a key mechanism of change, [47,48] findings supported the hypothesis that recovery support calls would have indirect effects on adolescents' post-treatment social risk, substance use, and substance-related problems via reductions in recovery environment risk.

In contrast to similar research that has suggested stronger effects of continuing care interventions for females, our study suggested the recovery support calls worked similarly well for both male and female adolescents. Additional research will be needed to further explore the extent to which recovery support services have differential effects for males and females, as well as the extent to which these effects may differ between adolescents and adults. Nonetheless, we are encouraged that these preliminary findings do not suggest the need for adapting services based on gender differences. As hypothesized, and similar to research suggesting continuing care interventions have stronger effects for individuals with lower levels of treatment readiness, [27,51] the recovery support calls used as part of the RSAF project did appear to have significantly greater effects for adolescents with lower treatment readiness at intake to treatment, at least with regard to its impact on reducing recovery environment risk. Again, additional research, preferably some of which include randomized designs, will be needed to examine the differential impact of recovery support services by level of treatment readiness.

Limitations

Despite being one of the more rigorous evaluations of recovery support services to date, findings of the current study must be viewed in light of at least two important limitations. First, although the use of a matched comparison sample provided a strong quasi-experimental design, such a design does not allow for as strong of inferences as randomized controlled trials. Second, while the results at the six-month follow-up suggest positive implications for recovery support calls, a six-month follow-up is inadequate to predict longer term recovery outcomes. Thus, future research should extend the length of follow-up for at least one year or longer.

Clinical and workforce implications

At least three key clinical implications may be drawn from the current study. First, the current study provides rare empirical evidence supporting the widely held, but little empirically supported assumption that recovery support services following episodes of formal outpatient and/or residential treatment are indeed effective in improving client outcomes. Thus, we hope that one important clinical implication of this study is that it serves as a springboard for both the provision of recovery support services in community-settings, as well as additional research to identify the most effective and cost-effective recovery support services. Second, this study supports other research with adolescents that suggest encouragement from treatment or continuing care staff to attend mutual aid meetings is predictive of greater attendance. Third, this study provided evidence that recovery support services do not necessarily have to be "peer-based," at least in terms of the recovery support service provider having the experiential credentials of being "in recovery."

Although acknowledged as a preliminary quasi-experimental finding, if these results can be replicated, an important workforce implication would be to broaden the base of the recovery support workforce. The development of effective recovery support models that utilize pre-professionals (e.g., college-level human service students) could have a significant impact on the extent to which recovery support services are delivered. Moreover, given the broad availability of college-level human service students that would potentially be both interested and available to volunteer (and earn course credit) to provide this service in

exchange for the opportunity to gain valuable applied experience, such recovery support models may have very good potential for successful implementation and sustainment, both of which are known issues within the substance use treatment field [19].

Conclusions and additional directions for future research

In conclusion, there is evidence that the provision of recovery support calls to adolescents following formal outpatient or residential substance use disorder treatment can be beneficial in terms of helping improve post-treatment outcomes, and such services may have greater impact for adolescents with lower levels of treatment readiness. Additionally, there is evidence for both the feasibility and effectiveness of using pre-professional volunteers to provide recovery support calls. Since the present positive outcomes were achieved with the majority of volunteers not having addiction recovery experience, the question of whether there are differences in outcomes based on the recovery status of those providing post-treatment recovery support services remains to be tested. Also left unanswered is the question of how the organizational setting through which recovery support services are provided to adolescents might affect key outcomes. It is unknown whether such services are best provided by an addiction treatment organization, research institute, recovery community organization, school, youth center, or other organization. Although the present results are promising, considerable research remains needed. There is clearly a need for randomized controlled trials, at least one of which is currently underway [77]. In addition to the need for research to provide support for the efficacy and effectiveness of recovery support services, however, is the need for research to better understand the cost-effectiveness and/or cost-benefits of providing evidence-based recovery support. Indeed, similar research has been suggested for continuing care research [78]. Finally, consistent with recommendations for research to identify methods to increase implementation of evidence-based continuing care interventions [20], we suggest the need to identify strategies to increase implementation of evidence-based recovery support services. Ideally, the current study will help serve as a springboard for greater empirical research related to post-treatment recovery support services to address these and other important questions that will ultimately lead to better outcomes for individuals impacted by substance use.

ACKNOWLEDGEMENT

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 (We stat Subcontract No. s8440 of SAMHSA Contract No. HHSS28320070006I) and the National Institute on Alcohol Abuse and Alcoholism, (grant no. R01 AA-021118). This publication reflects the views of the authors and do not reflect official positions of the government. The authors wish to acknowledge Randy Muck for his leadership in the field adolescent treatment and recovery, as well as project staff at each performance site for overseeing participant recruitment and follow-up and volunteer recruitment and supervision: Gina Grappone, Dave Hamolsky, Lisa Pineo, Bridget Ruiz, Stephanie Schade, Stephanie Springer, and Jamie Weber. This project would also not have been possible without the many volunteers who contributed their time and dedication providing support to youth. Finally, the authors want to acknowledge the work of Stephanie Kerns with manuscript preparation.

REFERENCES

1. Deas D, Thomas SE. An overview of controlled studies of adolescent substance abuse treatment. Am J Addict. 2001; 10: 178-189.
2. Waldron HB, Turner CW. Evidence-based psychosocial treatments for adolescent substance abuse. J Clin Child Adolesc Psychol. 2008; 37: 238-261.
3. Bender K, Tripodi SJ, Sarteschi C, Vaughn MG. A meta-analysis of interventions to reduce adolescent cannabis use. Res Soc Work Pract. 2011; 21: 153-164.
4. Tanner-Smith EE, Wilson SJ, Lipsey MW. The comparative effectiveness of outpatient treatment for adolescent substance abuse: a meta-analysis. J Subst Abuse Treat. 2013; 44: 145-158.
5. Waldron HB, Slesnick N, Brody JL, Turner CW, Peterson TR. Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. J Consult Clin Psychol. 2001; 69: 802-813.
6. Dennis M, Godley SH, Diamond G, Tims FM, Babor T, Donaldson J, et al. The Cannabis Youth Treatment (CYT) Study: main findings from two randomized trials. J Subst Abuse Treat. 2004; 27: 197-213.
7. Godley MD, Godley SH, Dennis ML, Funk RR, Passetti LL. The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. Addiction. 2007; 102: 81-93.
8. Hser YI, Anglin MD, Grella C, Longshore D, Prendergast ML. Drug treatment careers. A conceptual framework and existing research findings. J Subst Abuse Treat. 1997; 14: 543-558.
9. Dennis ML, Scott CK, Funk R, Foss MA. The duration and correlates of addiction and treatment careers. J Subst Abuse Treat. 2005; 28 Suppl 1: S51-62.
10. Scott CK, Dennis ML. Results from two randomized clinical trials evaluating the impact of quarterly recovery management checkups with adult chronic substance users. Addiction. 2009; 104: 959-971.
11. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA. 2000; 284: 1689-1695.
12. McKay JR. Is there a case for extended interventions for alcohol and drug use disorders? Addiction. 2005; 100: 1594-1610.
13. Dennis M, Scott CK. Managing addiction as a chronic condition. Addict Sci Clin Pract. 2007; 4: 45-55.
14. White WL, McLellan AT. Addiction as a chronic disease: key messages for clients, families and referral sources. Counselor. 2008; 9: 24-33.
15. McKay JR, Carise D, Dennis ML, Dupont R, Humphreys K, Kemp J, et al. Extending the benefits of addiction treatment: practical strategies for continuing care and recovery. J Subst Abuse Treat. 2009; 36: 127-130.
16. McKay JR. Effectiveness of continuing care interventions for substance abusers. Implications for the study of long-term treatment effects. Eval Rev. 2001; 25: 211-232.
17. McKay JR. Continuing care research: what we have learned and where we are going. J Subst Abuse Treat. 2009; 36: 131-145.
18. Blodgett JC, Maisel NC, Fuh IL, Wilbourne PL, Finney JW. How effective is continuing care for substance use disorders? A meta-analytic review. J Subst Abuse Treat. 2014; 46: 87-97.

19. Garner BR. Research on the diffusion of evidence-based treatments within substance abuse treatment: a systematic review. J Subst Abuse Treat. 2009; 36: 376-399.

20. Lash SJ, Timko C, Curran GM, McKay JR, Burden JL. Implementation of evidence-based substance use disorder continuing care interventions. Psychol Addict Behav. 2011; 25: 238-251.

21. McKay JR, Lynch KG, Shepard DS, Ratichek S, Morrison R, Koppenhaver J, et al. The effectiveness of telephone-based continuing care in the clinical management of alcohol and cocaine use disorders: 12-month outcomes. J Consult Clin Psychol. 2004; 72: 967-979.

22. McKay JR, Lynch KG, Shepard DS, Pettinati HM. The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes. Arch Gen Psychiatry. 2005; 62: 199-207.

23. Hubbard RL, Leimberger JD, Haynes L, Patkar AA, Holter J, Liepman MR, et al. Telephone enhancement of long-term engagement (TELE) in continuing care for substance abuse treatment: a NIDA clinical trials network (CTN) study. Am J Addict. 2007; 16: 495-502.

24. Cacciola JS, Camilleri AC, Carise D, Rikoon SH, McKay JR, McLellan AT, et al. Extending residential care through telephone counseling: initial results from the Betty Ford Center Focused Continuing Care protocol. Addict Behav. 2008; 33: 1208-1216.

25. Godley MD, Coleman-Cowger VH, Titus JC, Funk RR, Orndorff MG. A randomized controlled trial of telephone continuing care. J Subst Abuse Treat. 2010; 38: 74-82.

26. McKay JR, Van Horn DH, Oslin DW, Lynch KG, Ivey M, Ward K, et al. A randomized trial of extended telephone-based continuing care for alcohol dependence: within-treatment substance use outcomes. J Consult Clin Psychol. 2010; 78: 912-923.

27. McKay JR, Van Horn D, Oslin DW, Ivey M, Drapkin ML, Coviello DM, et al. Extended telephone-based continuing care for alcohol dependence: 24-month outcomes and subgroup analyses. Addiction. 2011; 106: 1760-1769.

28. Burleson JA, Kaminer Y, Burke RH. Twelve-month follow-up of aftercare for adolescents with alcohol use disorders. J Subst Abuse Treat. 2012; 42: 78-86.

29. McKellar J, Wagner T, Harris A, Oehlert M, Buckley S, Moos R. One-year outcomes of telephone case monitoring for patients with substance use disorder. Addict Behav. 2012; 37: 1069-1074.

30. Farabee D, Cousins SJ, Brecht ML, Antonini VP, Lee AB, Brummer J, et al. A comparison of four telephone-based counseling styles for recovering stimulant users. Psychol Addict Behav. 2013; 27: 223-229.

31. McKay JR, van Horn D, Ivey M, Drapkin ML, Rennert L, Lynch KG. Enhanced continuing care provided in parallel to intensive outpatient treatment does not improve outcomes for patients with cocaine dependence. J Stud Alcohol Drugs. 2013; 74: 642-651.

32. White WL. Peer-based addiction recovery support: history, theory, practice, and scientific evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center. 2009.

33. Valentine P. Peer-based recovery support services within a recovery community organization: the CCAR experience. Kelly JF, White WL, editors. In: Addiction recovery management: theory, science and practice. New York: Springer. 2011; 259-279.

34. Kaplan L. The role of recovery support services in recovery-oriented systems of care. DHHS Publication No (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 2008.

35. Ryan JP, Choi S, Hong JS, Hernandez P, Larrison CR. Recovery coaches and substance exposed births: an experiment in child welfare. Child Abuse Negl. 2008; 32: 1072-1079.

36. Davidson L, White W, Sells D, Schmutte T, O'Connell M, Bellamy C, et al. Enabling or engaging? The role of recovery support services in addiction recovery. Alcohol Treat Q. 2010; 28: 391-416.

37. Sinnett ER, Hagen K, Harvey WM. Credibility of sources of information about drugs to heroin addicts. Psychol Rep. 1975; 37: 1239-1242.

38. Lawson G. Relation of counselor traits to evaluation of the counseling relationship by alcoholics. J Stud Alcohol. 1982; 43: 834-839.

39. Mavis BE, Stöffelmayr BE. Program factors influencing client satisfaction in alcohol treatment. J Subst Abuse. 1994; 6: 345-354.

40. Brown BS, Thompson RF. The effectiveness of formerly addicted and nonaddicted counselors on client functioning. Drug Forum. 1975; 5: 123-129.

41. Connett GE. Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. Int J Addict. 1980; 15: 585-589.

42. Moos RH, Finney JW, Chan DA. The process of recovery from alcoholism. I. Comparing alcoholic patients and matched community controls. J Stud Alcohol. 1981; 42: 383-402.

43. McLellan AT, Woody GE, Luborsky L, Goehl L. Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. J Nerv Ment Dis. 1988; 176: 423-430.

44. Durlak JA. Comparative effectiveness of paraprofessional and professional helpers. Psychol Bull. 1979; 86: 80-92.

45. Pearl A. The paraprofessional in human service. Robbin S, Wagonfeld W, editors. In: Paraprofessionals in the human services. New York: Human Science Press. 1981.

46. Hattie JA, Sharpley CF, Rogers HJ. Comparative effectiveness of professional and paraprofessional helpers. Psychol Bull. 1984; 95: 534-541.

47. Godley MD, Kahn JH, Dennis ML, Godley SH, Funk RR. The stability and impact of environmental factors on substance use and problems after adolescent outpatient treatment for cannabis abuse or dependence. Psychol Addict Behav. 2005; 19: 62-70.

48. Garner BR, Godley MD, Funk RR, Dennis ML, Godley SH. The impact of continuing care adherence on environmental risks, substance use and substance-related problems following adolescent residential treatment. Psychol Addict Behav. 2007; 21: 488-497.

49. Carter RE, Haynes LF, Back SE, Herrin AE, Brady KT, Leimberger JD, et al. Improving the transition from residential to outpatient addiction treatment: gender differences in response to supportive telephone calls. Am J Drug Alcohol Abuse. 2008; 34: 47-59.

50. Kaminer Y, Burleson JA, Burke RH. Efficacy of outpatient aftercare for adolescents with alcohol use disorders: a randomized controlled study. J Am Acad Child Adolesc Psychiatry. 2008; 47: 1405-1412.

51. Lynch KG, Van Horn D, Drapkin M, Ivey M, Coviello D, McKay JR. Moderators of response to telephone continuing care for alcoholism. Am J Health Behav. 2010; 34: 788-800.

52. Godley SH, Meyers RJ, Smith JE, Godley MD, Titus JC, Karvinen T, et al. Adolescent Community Reinforcement Approach (A-CRA) for adolescent cannabis users. Cannabis Youth Treatment (CYT) Manual Series, Volume 4, DHHS Publication No. (SMA) 01-3489. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. 2001.

53. Godley SH, Godley MD, Karvinen T, Slown LL, Wright KL. The Assertive Continuing Care protocol: a clinician's manual for working with adolescents after residential treatment of alcohol and other substance use disorders. Bloomington, IL: Lighthouse Institute. 2006.

54. Dennis ML, Titus JC, White M, Unsicker J, Hodgkins D. Global Appraisal of Individual Needs (GAIN): administration guide for the GAIN and related measures. Version 5. Bloomington, IL: Chestnut Health Systems. 2003.

55. Dennis M, Titus JC, Diamond G, Donaldson J, Godley SH, Tims FM, et al. The Cannabis Youth Treatment (CYT) experiment: rationale, study design and analysis plans. Addiction. 2002; 97 Suppl 1: 16-34.

56. Godley MD, Godley SH, Dennis ML, Funk R, Passetti LL. Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. J Subst Abuse Treat. 2002; 23: 21-32.

57. Dennis ML, Dawud-Noursi S, Muck RD, McDermeit M. The need for developing and evaluating adolescent treatment models. Stevens SJ, Morral AR, editors. In: Adolescent substance abuse treatment in the United States: exemplary models from a national evaluation study. Binghamton, NY: Haworth Press. 2003; 3-34.

58. Dennis ML, Scott CK, Funk R. An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. Eval Program Plann. 2003; 26: 339-352.

59. Shane P, Jasiukaitis P, Green RS. Treatment outcomes among adolescents with substance abuse problems: the relationship between comorbidities and post-treatment substance involvement. Eval Program Plann. 2003; 26: 393-402.

60. Godley SH, Jones N, Funk R, Ives M, Passetti LL. Comparing outcomes of best-practice and research-based outpatient treatment protocols for adolescents. J Psychoactive Drugs. 2004; 36: 35-48.

61. Dennis ML, Chan YF, Funk RR. Development and validation of the GAIN Short Screener (GSS) for internalizing, externalizing and substance use disorders and crime/violence problems among adolescents and adults. Am J Addict. 2006; 15 Suppl 1: 80-91.

62. Lennox R, Dennis ML, Ives M, White MK. The construct and predictive validity of different approaches to combining urine and self-reported drug use measures among older adolescents after substance abuse treatment. Am J Addict. 2006; 15 Suppl 1: 92-101.

63. Lennox R, Dennis ML, Scott CK, Funk R. Combining psychometric and biometric measures of substance use. Drug Alcohol Depend. 2006; 83: 95-103.

64. Rosenbaum PR, Rubin DB. The central role of the propensity score in observational studies for causal effects. Biometrika. 1983; 70: 41-55.

65. Dehejia RH, Wahba S. Propensity score-matching methods for nonexperimental causal studies. Rev Econ Stat. 2002; 84: 151-161.

66. Bollen KA. Multiple indicators: internal consistency or no necessary relationship? Qual Quant. 1984; 18: 377-385.

67. Titus JC, Dennis ML, White WL, Scott CK, Funk RR. Gender differences in victimization severity and outcomes among adolescents treated for substance abuse. Child Maltreat. 2003; 8: 19-35.

68. Dennis ML, Funk R, Godley SH, Godley MD, Waldron H. Cross-validation of the alcohol and cannabis use measures in the Global Appraisal of Individual Needs (GAIN) and Timeline Followback (TLFB; Form 90) among adolescents in substance abuse treatment. Addiction. 2004; 99 Suppl 2: 120-128.

69. Arbuckle JL. AMOS 16 users guide. Chicago: IBM SPSS. 2007.

70. Mehrotra DV, Li X, Liu J, Lu K. Analysis of longitudinal clinical trials with missing data using multiple imputation in conjunction with robust regression. Biometrics. 2012; 68: 1250-1259.

71. Browne MW, Cudeck R. Alternative ways of assessing model fit. Sociol Methods Res. 1993; 21: 230-258.

72. Tucker LR, Lewis C. The reliability of coefficient for maximum likelihood factor analysis. Psychometrika. 1973; 38: 1-10.

73. Bentler PM. Comparative fit indexes in structural models. Psychol Bull. 1990; 107: 238-246.

74. Hu L, Bentler PM. Cutoff criteria for fit indexes in covariance structure analysis: conventional criteria versus new alternatives. Struct Equ Modeling. 1999; 6: 1-55.

75. Kelly JF, Dow SJ, Yeterian JD, Kahler CW. Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. Drug Alcohol Depend. 2010; 110: 117-125.

76. Passetti LL, Godley SH, Godley MD. Youth participation in mutual support groups: history, current knowledge and areas for future research. J Groups Addict Recover. 2012; 7: 253-278.

77. Godley MD. Effectiveness of Volunteer Telephone Continuing Care (VTCC) for adolescents with alcohol and other drug use disorders. R01 AA021118. National Institute on Alcohol Abuse and Alcoholism (NIAAA); 2012.

78. Popovici I, French MT, McKay JR. Economic evaluation of continuing care interventions in the treatment of substance abuse: recommendations for future research. Eval Rev. 2008; 32: 547-568.

Cite this article

Garner BR, Godley MD, Passetti LL, Funk RR, White WL (2014) Recovery Support for Adolescents with Substance use Disorders: The Impact of Recovery Support Telephone Calls Provided by Pre-Professional Volunteers. J Subst Abuse Alcohol 2(2): 1010.



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: Haberle, B., Conway, S., Valentine, P., Evans, A.C., White, W. & Davidson, L. (2014). The recovery community center: A new model for volunteer peer support to promote recovery. *Journal of Groups in Addiction and Recovery*, 9, 237-256.
http://www.tandfonline.com/doi/full/10.1080/1556035X.2014.943553#.VBQpkvldVAE
Posted at **www.williamwhitepapers.com**

The Recovery Community Center: A New Model for Volunteer Peer Support to Promote Recovery

ABSTRACT

The last decade has seen new forms of peer support emerge from a "new addiction recovery advocacy movement." One structure for organizing these services is the recovery community center (RCC), which combines the social fellowship of AA with the service mission of a drop-in center, while offering new services like recovery coaching. The backbone of the RCC is its volunteers from the recovery community, who instill hope, role model recovery, and dispel stigma. We describe this model and provide data from two RCCs. These data suggest that RCCs may serve as hubs of recovery-oriented systems of care, serving as the impetus for more rigorous research to be conducted on the role and effectiveness of this emerging form of service delivery.



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. (2014). Tribute to the "recovery movement." ATTC Messenger, Accessed September 6, 2014 at http://www.attcnetwork.org/find/news/attcnews/epubs/addmsg/September2014article.asp
Posted at **www.williamwhitepapers.com**

Tribute to the "Recovery Movement"

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The effective management of historically intractable problems requires the sustained mobilization of multiple community institutions. Such mobilization is achieved through social movements that redefine the nature and complexity of the problem and forge systemic approaches to its solution. The history of American responses to alcohol and other drug (AOD) problems is dotted with such social movements, from therapeutic and mutual aid movements to movements that promised drug prohibition (or legalization) as the ultimate solution to these problems. Collectively, earlier movements drew from two primary sources: knowledge drawn from the study of AOD-related personal and social pathologies, and knowledge drawn from short-term evaluation of clinical or social interventions into these problems. Recently, a third source of knowledge—lessons drawn from the lived experience of long-term addiction recovery—has risen from within what is popularly referred to as the "recovery movement." But what exactly is this recovery movement, and what new perspectives and approaches does it offer?

History of Recovery Movement

Abstinence-based therapeutic, religious, and cultural revitalization movements date to the mid-1700s, and mid-twentieth century policy advocacy organizations (e.g., the National Council on Alcoholism) led by people in recovery played a significant role in creating the cultural and political will to forge the modern network of addiction treatment institutions in the United States. Those recovery advocacy efforts peaked in the U.S. in the early 1980s and were followed by the restigmatization, demedicalization, and increased criminalization of addiction through the 1980s and 1990s. Progressive disillusionment with these latter trends set the stage for the emergence of a reformulated and much more potent "recovery movement."

That power is illustrated by a comparison of two historical milestones. In

1976, the National Council on Alcoholism sponsored Operation Understanding—an event in which 52 prominent Americans (politicians, sports heroes, movie stars, and business leaders) stood before television cameras to announce their status as individuals in long-term recovery from alcoholism. Never before had individuals in such number and of such cultural prominence acknowledged recovery from alcoholism. In 2013, more than 120,000 people in addiction recovery and their families and allies marched in public Recovery Month celebration events—something many long-tenured recovery advocates could not have imagined happening in their lifetime. That unprecedented level of cultural and political mobilization of individuals and families in recovery emerged from new and renewed grassroots recovery community organizations (RCOs) in the late 1990s (supported in part by the Center for Substance Abuse Treatment's Recovery Community Support Program), the 2001 Recovery Summit in St. Paul, Minnesota, that launched Faces and Voices of Recovery, and efforts by affiliates of the National Council on Alcoholism and Drug Dependence to return to their advocacy roots. Recently, the growing network of RCOs has been further organized within the Association of Recovery Community Organizations (ARCO). Today's "recovery movement" or "new recovery advocacy movement," like most social movements, is really multiple movements with broadly shared ideas and strategies.

A Recovery Mutual Aid Movement

The "recovery movement" grew out of and simultaneously fueled the growth and philosophical diversification of addiction recovery mutual aid organizations. Of great import is the growing accessibility of local recovery support resources that today span secular, spiritual, and religious pathways of long-term addiction recovery. What the "recovery movement" is doing is embracing these groups culturally, without formal linkages or formal mutual endorsement, around such kinetic ideas as:

- Long-term addiction recovery is a reality in the lives of millions of individuals and families.
- There are many pathways to addiction recovery—and ALL are cause for celebration.
- Recovery gives back to individuals, families, and communities what addiction has taken.

Individuals who once defined themselves as AA members, NA members, Women for Sobriety members, SMART Recovery members, Lifering Secular Recovery members, Celebrate Recovery members (and on and on) are today beginning to also see themselves within a larger identity: "people in long-term addiction recovery." That extension of identity marks the emergence of an ecumenical culture of recovery in the United States. Of equal import is the growth of Internet-based mutual support media through which that broader identity is expressed. A day could come faster than any could predict when more people will participate in online recovery mutual support activities than participate in local face-to-face recovery support meetings.

A Recovery Community Building Movement

Historically, support for addiction recovery in the U.S. came from two primary social institutions—recovery mutual aid societies and professionally directed addiction treatment institutions. What is of considerable import is the recent growth of recovery support institutions that fit neither of these categories. These new institutions include recovery community centers, recovery residences, recovery schools (at high school and collegiate levels), recovery industries, recovery ministries, recovery cafes, and recovery-focused venues in such areas as sport, travel, theatre, and film. This marks a shift from a near-exclusive focus on intrapersonal processes of addiction

recovery to creating local *recovery landscapes* (a potent form of *community recovery capital*) within which recovery can flourish. Using a clinical metaphor, the community is becoming the patient. Persons in or recently completing addiction treatment are leaving the doorways of their homes as you read this. Where will they go and what will they do? The answers to those questions underscore the need for physical, cultural, and social space in local communities supportive of addiction recovery.

A Treatment Transformation Movement

Processes of professional self-inventory and systems performance evaluation in the opening decade of the twenty-first century triggered calls to: 1) shift the field's organizing center from pathology and intervention paradigms to a recovery paradigm, 2) extend the design of addiction treatment from one focused almost solely on acute biopsychosocial stabilization (recovery initiation) to one that encompassed support for long-term personal and family recovery (recovery maintenance and enhanced quality of life in recovery), and to 3) nest these models of sustained addiction recovery management (ARM) within larger recovery-oriented systems of care.

The calls for this conceptual shift in the field were not without challenges. Critics challenged that the recovery concept was amorphous ("Is it like pornography? You can't define it but you know it when you see it?"), redundant ("We're already recovery oriented."), faddish ("a flavor of the month"), impractical ("No one will fund long-term recovery support."), and dangerous ("Recovery is a political Trojan horse aimed at de-professionalizing, delegitimizing, and defunding science-based treatment and harm reduction services."). Such were the challenges that faced early ARM/ROSC pilot settings (e.g., the State of Connecticut and the City of Philadelphia) and recovery-focused policy shifts within the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (as promulgated through CSAT's Addiction Technology Transfer Network) and the White House Office of National Drug Control Policy.

So what does this call for increased recovery orientation really mean for the future of addiction treatment? It means that system resources are strategically allocated toward the vision of long-term personal, family, and community recovery and wellness. It means that the principles imbedded within the care process are drawn from the lived experience of personal and family recovery and that people in recovery have visibility and voice throughout the system. It means that the benchmarks used to measure the performance of roles, organizations, and systems all have a direct or indirect nexus to personal and family recovery. It means that measures of traditional systems health (e.g., number of people served, number of units of service, number of organizational staff, service costs, organizational budgets) have virtually no meaning and value unless linked to measurable, sustainable long-term recovery outcomes. As outlined, ARM/ROSC will touch nearly every aspect of addiction treatment, including issues of attraction, access, engagement, locus of service delivery, service team composition, service menu, service dose, linkage to indigenous recovery community resources, and the expansion of post-treatment recovery check-ups and stage-specific recovery supports.

A Policy Advocacy Movement

The "recovery movement" also contains a strong policy advocacy arm that, in addition to its recovery community building activities and support of ARM/ROSC, is:

- demanding substantial and authentic representation of people in recovery in all AOD-related policy forums,
- challenging ill-informed and stigmatizing public portrayals of people experiencing or recovering from AOD-related problems,
- challenging discriminatory laws and policies that constitute obstacles to recovery,

- promoting pro-recovery laws and social policies,
- promoting programs of professional, public, and political education, and
- promoting development and funding of a recovery-focused research agenda.

A central tenet within the advocacy movement is that people who were once part of the problem can become part of the solution to AOD problems in local communities throughout the United States.

Closing Reflection

As we celebrate Recovery Month in 2014, it is fitting that we pay homage to the people in recovery and the professional pioneers who have played such integral roles in this revolution in thinking and service practice. Only time will tell whether recovery as a new organizing paradigm will reap its potential promises or will be colonized, corrupted, and commercialized in ways that will render it one more "flavor of the month" cast into the dust bin of history. But make no mistake, the "recovery movement" so briefly described here does have the potential to transform addiction treatment as a system of care and transform local community life in the United States.

About the Author: William White is Emeritus Senior Research Consultant with Chestnut Health Systems and a volunteer consultant with Faces and Voices of Recovery and other recovery advocacy organizations. He is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

References

Evans, A.C., & White, W.L. (2013). "Recovery-oriented systems of care": Reflections on the meaning of a widely used phrase. Posted at www.williamwhitepapers.com

Kelly, J. F., & White, W. L. (Eds., 2011). *Addiction recovery management: Theory, science and practice*. New York: Springer Science

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. (1998, 2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W., Kelly, J., & Roth, J. (2012). New addiction recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, *7*(2-4), 297-317.

White, W.L. & Evans, A.C. (2014). The recovery agenda: The shared role of peers and professionals. *Public Health Reviews, 35*(2), 1-15.

White, W. & Tuohy, C.M. (2013) Recovery-oriented practice and the addictions professional: A systems perspective. *Advances in Addiction and Recovery (NAADAC)*, Summer Issue, pp. 22-23.



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. (2014). Young people in the new recovery advocacy movement. *Counselor*, 15(2), 64-69. Posted at **www.williamwhitepapers.com**

Young People in the New Recovery Advocacy Movement

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

"A small body of determined spirits filled by an unquenchable faith in their mission can alter the course of history." –Mahatma Gandhi

In the late 1990s, new grassroots recovery community organizations (RCOs) began to dot the American landscape. These RCOs and the recovery community centers they spawned defied categorization as either recovery mutual aid organizations or addiction treatment organizations. In 2001, recovery advocates representing RCOs from across the country came together in St. Paul, Minnesota, to officially launch a new recovery advocacy movement. This article describes the growing role of young people in the new recovery advocacy movement and introduces Justin Luke Riley, one of the young leaders of a new organization—Young People in Recovery—that is bringing great energy and vision to that movement.

The New Recovery Advocacy Movement

Organizationally, the new recovery advocacy movement brought together resources from multiple national organizations, including the Johnson Institute, the National Council on Alcoholism and Drug Dependence, the Legal Action Center, and the newly formed Faces and Voices of Recovery, but its strength remained within its grassroots RCOs and their growing memberships. Five kinetic ideas formed the heart of this movement: 1) addiction recovery is a living reality for individuals, families, and communities, 2) there are many (religious, spiritual, secular) pathways to recovery, and all are cause for celebration, 3) recovery flourishes in supportive communities, 4) recovery is a voluntary process, and 5) recovering and recovered people are part of the solution: recovery gives back what addiction has taken from individuals, families, and communities.

In its early years, the national movement and its local RCOs focused on eight core strategies: 1) building strong, grassroots RCOs and linking these RCOs into a national movement, 2) advocating for meaningful, authentic, and diverse recovery representation at local, state, and federal policy levels, 3) assessing local recovery

support needs, 4) educating the public, policymakers, and service providers about the prevalence and pathways of long-term addiction recovery, 5) expanding philanthropic and public support for addiction treatment, recovery support services, and recovery advocacy and cultivating volunteerism within local communities of recovery, 6) creating recovery community centers as a focal point for the delivery of non-clinical, peer-based recovery support services, 7) celebrating recovery from addiction through major public events, and 8) supporting recovery-focused research.

The 12 years since the historic St. Paul Recovery Summit have witnessed the growing vibrancy and diversification of this recovery advocacy movement. Recovery has emerged as a major organizing paradigm within the addictions field with programs across the country seeking to extend addiction treatment from a model of acute biopsychosocial stabilization to models of sustained recovery management nested within larger recovery-oriented systems of care. People in recovery have been culturally and politically mobilized at an unprecedented level. This past September, more than 100,000 people in recovery and their families and allies participated in public recovery celebration events across the country—something that would have been unimaginable only a few years ago.

Two emerging trends portend even greater power and influence of the new recovery advocacy movement. The first is the growing mobilization of family members affected by addiction, particularly parents who have lost a child to addiction. This is evident in new mutual aid structures (e.g., Grief After Substance Passing), grieving parents finding creative ways to share their stories through books (e.g., David Scheff's *Beautiful Boy*) and films (e.g., Jim Contopulos' *More than an Addict*), and parents such as Stacie Mathewson (Transforming Youth Recovery) and Gary Mendell (We Are Shatterproof) who are turning their grief into powerful advocacy voices and are forging new long-term recovery support systems for young people.

A second trend is the growing involvement of young people in the new recovery advocacy movement and the influence they are exerting on that movement. An example of this influence is the film *The Anonymous People* developed by the young, brilliant filmmaker Greg Williams, which has been viewed by more than 30,000 people since its 2013 release. Nothing has been more effective in revitalizing and expanding involvement in the advocacy movement than the local screenings of this film. Also of note are the increasing roles young people are playing in organizations like Faces and Voices of Recovery and the Association of Recovery Schools as well as within local RCOs.

Nothing better illustrates the growing presence and leadership of youth in recovery than the early history of the newly formed organization, Young People in Recovery (YPR). I recently interviewed Justin Luke Riley about the history and future of YPR. That interview is reproduced here in abridged form (see www.williamwhitepapers.com for the full interview). I hope you will find this conversation as engaging and inspiring as I did.

Early History of Young People in Recovery

Bill White: Justin, could you share the story of how you came to be involved in recovery advocacy and with Young People in Recovery (YPR)?

Justin Luke Riley: Absolutely. First, let me introduce myself to our readers. My name is Justin Luke Riley, and I'm a young person in recovery. For me, that means that I've learned to be a much better son and an asset to my community, and I'm still learning how to be a husband. (I've only been married for two-and-a-half years.) It also means to me that I've been alcohol- and other drug-free since November of 2007. In November of 2007, I heard a message that was very simple and clear—and that was my need to help others in whatever way I could. And so I began at age 19 to carry the recovery

message—to let other young people know that it is okay and even exciting to be in recovery.

I was then asked to participate in something that changed my life. It was a government-funded conference in December 2010, and I was asked to share that I was in recovery and how that had happened. I talked about my friends, and how people around me were helping me, my family, and my Nanna and going back to school. At this meeting, there were other young people who kept saying, "We're part of CRC at Rutgers." I finally interrupted and said, "I don't know what you mean when you keep saying you're part of CRC. Is that a treatment center? Is that a new AA thing?" And they said, "No, it's a collegiate recovery community. There's a house on Rutgers University that supports us and our journey to recovery. Some of us go to twelve-step meetings. Some of us just learned a different way to live without abusing substances" and so-on-and-so-forth. And I was flabbergasted, Bill. I'd never heard of this. I asked them, "So basically, it's just like Hogwarts for kids like us who need an alternative environment?" And I said, "Your campus not only knows your history, but they're supporting you in your recovery? That's amazing to me."

Those present included Devin Fox, Daniel Turino, Benjamin Shand, Sarah Nerad, Aaron Hoffman, Mike Deagros, and others who would later play important roles in YPR. Young People in Recovery was really birthed out of the sharing that began at that conference and at a follow-up conference held in July 2011.

Bill White: What is your recollection of the early vision or hopes of what YPR could achieve?

Justin Luke Riley: We had this vision of empowering young people, of carrying a message of hope, not proposing we have the best way to recover, not endorsing a certain kind of recovery, but just lifting up all these great things that we'd experienced and heard about. After those first two meetings, there were frequent conference calls until 11:00 at night because so many of us obviously were either working or going to school. Those first calls were, "Hey, what's happening in your part of the country?" type of exchanges. We finally came up with a vision and a mission statement. And we met again in Bethesda with some outside help to do some strategic planning to formalize ourselves as an organization. So many people believed in us: Faces and Voices of Recovery, the National Recovery Foundation, SAMHSA, and the Stacie Mathewson Foundation.

Our really big vision is a world where all young people in or seeking recovery can achieve their potential in life. And we wanted to be as inclusive as possible—embracing people in traditional 12-step programs to harm reduction programs and everything in between, from SMART Recovery to the All Recovery Meetings that are becoming more popular among young people. We wanted to be supportive of any way a young person could find recovery.

Structure and Financing of YPR

Bill White: How is YPR currently structured?

Justin Luke Riley: Young People in Recovery is incorporated in good standing in the state of Colorado. It is governed by an advisory board made of people from coast to coast—some in the addiction recovery field and some who are representatives from foundations or other non-profit organizations. The advisory board meets by conference call each month, at which time the finances and budget are reviewed and plans made for the continuing future of YPR. Our 501(c) 3 status is pending with officers, including a chair and vice-chair of the board of directors and a secretary and treasurer. Like other organizations, we have bylaws and committees.

YPR has three staff members, two of which are coming on in a more full-time capacity in January 2014. These positions include the Vice President of Communication filled by A.J. Senerchia who's been with YPR a little over a year now, and Douglas Rudolph, who's our Chief

Public Policy Officer. They're both wonderful leaders who have volunteered thousands of hours to the cause of Young People in Recovery. A.J. makes sure that all chapters know how to recruit volunteers, host a YPR chapter meeting, and manage themselves financially. Doug helps us continue to be aware of all of the rules and the very strict guidelines that distinguish education and advocacy from lobbying. Doug has a meeting with the Office of National Drug Control Policy (ONDCP) at the White House coming up in the next few weeks. We have worked very closely with ONDCP over the last few years. I'm the President and CEO of Young People in Recovery and was the Chair of the National Leadership Council before we were fully organized as a non-profit organization. My job is to develop a business model for YPR to assure its sustainability and to meet with the YPR chapters and support them in any way I can.

Another person I would like to mention is Devin Fox. He was the trailblazer who carried YPR on his shoulders in our early days. I can confidently say that without Devin Fox, YPR wouldn't be where it is today and might not even still be here. Devin kept us all together in those early days and solidifies our relationships with key organizations. Mike DeAgro, our current Board Chair, also deserves acknowledgement for bringing YPR to its present level of development.

Bill White: How has YPR been financially supported?

Justin Luke Riley: The way we've been funded so far is from key partners. SAMHSA paid for us to get together for our early strategic planning and, through Abt Associates, provided the consultants that guided our early organizational efforts. The National Youth Recovery Foundation and Faces and Voices of Recovery both housed us within their umbrella before we became an independent organization. Two foundations—the Bridge Foundation and the Stacie Mathewson Foundation—have supported us. The Stacie Mathewson Foundation is by far the largest financial supporter we have had to date.

YPR Chapters

Bill White: You have referenced state and local chapters of YPR. Could you describe the current state of chapter development?

Justin Luke Riley: Yes. We now have more than ten chapters. It's a bit tough pinning this number down because there is no ironclad rule of what it takes to be a chapter. We don't say, "Hey, if you want to have a chapter, it has to have these five ingredients and if it doesn't, then you can't be a chapter." What we have are suggested guidelines of how different chapters have organized themselves and what types of activities they have pursued. Some of our chapters, like the one here in Denver, Colorado, where I live, are promoting collegiate recovery programs and promoting the development of recovery community centers. The Colorado YPR chapter has a facility where chapter meetings, twelve-step meetings, and All Recovery meetings are held. And they provide some peer-based recovery support services through the Access to Recovery program. The major recovery advocacy organization in Colorado, Advocates for Recovery, is also housed at the YPR facility.

In contrast, we have a YPR chapter in Ohio that focuses on sponsoring sober events such as bowling or going to athletic games to help people have a social life in recovery that is not centered around alcohol and drugs. Other chapters have more of a public policy focus. Many of our YPR chapters, such as those in Reno and L.A. focus their efforts on supporting their collegiate recovery programs. At the end of the day, the mission of each chapter is to identify, prioritize, and respond to the recovery support needs of young people in their community. Bill, what that looks like is helping them getting back to college, helping them get jobs, helping them navigate the pre- or post-treatment world, helping them socially integrate and thrive and contribute as a recovering person within the community.

What we've done is turned it all upside down. Rather than having a set program we want everyone to replicate around the country, we are asking local chapters to define what their community needs and then we are supporting them in their efforts to meet those needs. One of the ways we're going to offer that support is to host national leadership conferences every year and develop young leaders in recovery from across the country and give them opportunities to learn from each other. We're going to have young people from diverse cultural settings have the opportunity to be nominated to participate in these conferences. We don't want any financial barriers to keep anyone from creating a YPR chapter and participating in these conferences. Instead of our staff flying around everywhere telling everyone what to do, we are going to bring everyone together to share what is working within local communities in terms of recovery support for young people. And we will have some of our key partners, such as Faces and Voices of Recovery, also represented at these meetings. And we are putting money in our national budget to help local YPR chapters seed some of their key activities.

Bill White: Justin, what can Young People in Recovery as an organization and young people in recovery bring to shape the future of the larger recovery advocacy movement in the U.S.?

Justin Luke Riley: I think we're going to be able to change the way people in our country view addiction and recovery. I know that's a big statement and that this will require a huge culture shift, but I do believe that Young People in Recovery, and not only as an organization, but just what we are doing to mobilize young people as an advocacy force will have this effect. I see the changes in people's faces when I say, "I used to be homeless but today I'm in recovery and I'm married and productive." Young people are going to be able to, through their stories, change the public perception of addiction recovery and mental health recovery.

Personal Reflections

Bill White: What has your involvement in YPR meant to you personally?

Justin Luke Riley: I'm 25 years old and I got involved when I was 21. I've lost about 20 of my closest friends due to addiction. Today, I have the sense that part of my destiny is to give people hope and help. My mentor once told me, "One day, you're going to be able to help a lot of people. God made you specifically for that. And you're not perfect and you never will be, but you're going to be able to influence others and you're going to be able to let people know that there is hope, that there is a solution and you're going to be able to carry that message forward." And he told me very clearly that this isn't about ego. It was about a larger purpose in my life. There's a higher power I choose to call God, and me and God are working together to try to help people. This is not just a social thing or a rite of passage for me. It's about this larger need in the community and a larger purpose in my life related to that need. I know that I have a Batman complex sometimes, but I know that recovery is possible. I mean, my dad was the best man at my wedding. There was a time when my family did not speak to me because of the things that I had done and the destruction I was wreaking in my life. And my dad is in recovery himself now! He lets me tell people. He didn't used to, but then he saw clips from [the film] *Anonymous People* and he called me and he said, "I finally get it." And he said, "If you ever need help telling people that there's a solution, let me know." And so, for me, Bill, it doesn't get more personal than that. Recovery saved my life, my father's life, my family's life, and it's given me a new life. And I saw a lot of lives lost along the way. I know YPR is now saving and changing lives.

Getting Involved

Bill White: Justin, let me ask a final question. How can young people in recovery get involved in YPR or addiction professionals get more information about YPR?

Justin Luke Riley: They can directly e-mail me at jl.riley21@gmail.com or they can directly e-mail the Vice President of Communication, whose contact information is on our website (http://youngpeopleinrecovery.org), or they can go to our Facebook page (https://www.facebook.com/youngpeopleinrecovery) and message us. If anyone sends us a message, A.J. or myself will call to follow up. We love doing Google Hangouts because we can see each other. So contact us and we'll set up a Google Hangout, Facetime, or Skype. We'd love to support development of a YPR chapter near you.

Bill White: Justin, thank you for taking this time with us and thank you for all you are doing for young people and their families.

Justin is just one of a legion of advocates among the largest generation of young people in recovery in history. The future of addiction recovery in America may well rest in their hands.

About the Author: William ("Bill") White is Emeritus Senior Research Consultant at Chestnut Health Systems and a volunteer consultant to Faces and Voices of Recovery. He has a Master's degree in Addiction Studies from Goddard College and has worked in the addictions field since 1969. Bill has authored or co-authored more than 500 articles, monographs, research reports, interviews and book chapters and 17 books, including *Slaying the Dragon - The History of Addiction Treatment and Recovery in America* and *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement.* Bill's collected papers and weekly blogs can be found at www.williamwhitepapers.com.

Acknowledgement: Support for this interview was provided by the Great Lakes Addiction Technology Transfer Center (ATTC) through 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 view of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA, or CSAT.

References and Recommended Reading

Coyhis, D. (2011). *The Wellbriety Movement comes of age*. Aurora, CO: Coyhis Publishing, Inc.

White, W. L. (2001). The new recovery advocacy movement: A call to service. *Counselor, 2*(6), 64-67.

White, W. L. (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.

White, W. L. (2007). The new recovery advocacy movement in America. *Addiction, 102,* 696-703.

White, W. L. (2013). Loved ones GRASPing for help: An Interview with Denise and Gary Cullen. Posted at www.williamwhitepapers.com

White, W. L. (2013). From private grief to public advocacy: An Interview with Jim Contopulos. Posted at www.williamwhitepapers.com

White, W. L. (2013). State of the new recovery advocacy movement. Posted at www.williamwhitepapwers.com



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. (2015). Congress 60: An addiction recovery community within the Islamic Republic of Iran. *Alcoholism Treatment Quarterly*, 33(3), 328-347. Posted at www.williamwhitepapers.com

Congress 60:
An Addiction Recovery Community within the Islamic Republic of Iran

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Abstract

The Islamic Republic of Iran, in response to the highest rate of opium consumption in the world, has devoted substantial resources to reduce drug availability and address addiction-related problems. Demand-reduction activities have included residential rehabilitation centers, outpatient treatment centers, and support for addiction recovery mutual aid organizations such as Narcotics Anonymous. The growing role of voluntary non-governmental organizations (NGOs) in supporting addiction recovery in Iran has not been fully described in the professional literature. This report describes one such NGO, Congress 60, which was founded in 1998 and has since grown to 38 branches in Iran with more than 20,000 members. Included in the review are the history, governance, philosophy, and recovery support methods of Congress 60.

Keywords: Iran, Congress 60, Hossein Dezhakam, DST Method, opium tincture

Introduction

The use of opium and other intoxicants among the people of Iran has a very long history (Matthee, 2005), but problems related to addiction escalated dramatically in the second half of the twentieth century, with estimates of the number of Iranians meeting DSM-IV criteria for substance dependence estimated between 1-4 million (Ahmadi et al., 2007; Mokri, 2002; Razzaghi, Rahnimi, Hosseni, Madani, & Chaterjee, 1999; Sharifi et al., 2012). This rising rate of addiction is in marked contrast to recent overall improvements in health, life expectancy, and education in Iran. Increased opiate addiction is related to a confluence of factors: proximity to Afghanistan—the world's leading source of opiates—and Pakistan; a youthful population (half under age 19); urbanization and social dislocation; and the financial distress and unemployment

exacerbated by UN and EU economic sanctions against Iran (Razzaghi et al., 1999; Shariatirad & Maarefvand, 2013). Surveys of drug use in Iran report a dramatic rise between 1973 and 1978, a decline of use in the early years following the Iranian Revolution, and a subsequent resurgence beginning in the years 1988-1992 (Rahimi-Movaghar, Mohammad, & Razzaghi, 2002).

The patterns of drug use in Iran primarily involve the smoking of opium residue (shire and sukhte) in pipes; the ingestion (dissolved in tea) of opium (thariac); and the smoking, inhalation, or injection of heroin, with growth in injection drug use contributing to increases in HIV and HCV infection (Mokri, 2002). Most (71%) of the opium and heroin consumed in Iran is purchased from illicit street dealers, often costing less than a pack of cigarettes. Opium is generally consumed in one's home or at a coffee or teashop, and heroin is most often consumed in a location outside the home (Razzaghi et al., 1999). A common form of street heroin is called Kerack—not to be confused with crack cocaine, which is rarely used in Iran (Mehrjerdi, 2013; Mohammad, Hassan, & Dariush, 2011). Like heroin dependence, cessation of prolonged opium use produces both an acute and protracted (for months) withdrawal syndrome associated with intense drug cravings and drug-seeking behaviors, making the challenge not the initiation of recovery but the maintenance of long-term recovery (Rahimi-Movaghar et al., 2009).

The typical profile of persons addicted to opioids in Iran is that of a married (62%) male (95%) between the ages of 14-75 (mean of 35) with limited education (more than half without a high school diploma or college degree) who is supported by and living with family while working in a skilled, semi-skilled, or unskilled job (Ahmadi & Motamed, 2003; Sharifi et al., 2012; Shekarchizadeh, Ekhtiari, Khami, & Virtanen, 2012). Drug use, with opium as the most frequent initial drug, begins most often between the ages of 12-18 and is initiated in the context of friends or family, with nearly half of those entering treatment reporting another person addicted within their family (Day, Nassirimanesh, Shakeshaft, & Dolan, 2006; Mokri, 2002; Sharifi et al., 2012). Women are most frequently introduced to drug use by their drug-using partner (Dolan, Salimi, Nassirimanesh, Mohsenifar, & Mokri, 2011). The majority (75%) of those entering treatment for addiction also present with a co-occurring psychiatric illness (Ghanizadeh, Ashkani, & Maany, 2000). Injection drug users are primarily single males between the ages of 20-39 (with a trend toward decreasing age of use; Ataee et al., 2014), with prior histories of addiction treatment and incarceration and high rates of HIV and HCV infection (Eskandarieh et al., 2013; Shahrbabaki et al., 2011; Zamani et al., 2006). Most opium and heroin users in Iran report multiple failed attempts to cease their drug use (Razzaghi et al., 1999).

Cultural and legal responses to addiction have a long history in Iran (Matthee, 2005). Before the 1979 revolution, there was a trend toward the decriminalization and medicalization of addiction with growth in government-funded detoxification, inpatient addiction treatment, pilot outpatient treatment, and ancillary services that included education and vocational rehabilitation. Opium rationing for older addicts also provided an early harm reduction effort in Iran (Afkhami, 2009).

Following the fall of the shah in the 1979 Iranian Revolution, addiction was increasingly viewed through the lens of Islamic moral precepts. The Council of Islamic Revolution in Iran waged a "jihad against sin" that included a ban on poppy cultivation, closing of detoxification and treatment centers, and harsh anti-drug measures—fines, corporal punishment (lashings), incarceration in labor camps, and the possibility of death for drug trafficking (Calabrese, 2007; Figg-Franzoi, 2011). Temporary reductions in opium supplies during this period inadvertently contributed to rising heroin use among opiate-dependent citizens. During the early 1980s, provisions made for distribution of opium to confirmed addicts were reinstituted and some detoxification and rehabilitation centers were opened to receive addicts mandated from the courts, but alarm continued over the

rising tide of opiate addiction and the growing percentage of prison inmates incarcerated for drug offenses (Afkhami, 2009; Calabrese, 2007). The allocation of resources for drug supply and drug demand reduction efforts was, however, limited through much of the 1980s due to the Iran-Iraq War.

The late 1990s were marked by a remedicalization of addiction in Iran. This followed increased recognition of rising rates of addiction and injection drug use and growing concern about AIDS and the 25% HIV infection rate among injection drug users (Afkhami, 2009). As a result, the Iranian government recommitted itself to a balance of demand and supply reduction efforts that expanded resources for addiction treatment and recovery support services (Calabrese, 2007). Early prevention and treatment activities were supported and coordinated through the State Welfare Organization (Aliverdinia & Pridemore, 2008). Key milestones included expanded detoxification, inpatient and outpatient treatment, and harm reduction resources, including more than 100 outpatient clinics established by 2000 (Afkhami, 2009). There was widespread use of pharmacotherapy (naltrexone and methadone maintenance) in hospitals (2000), outpatient clinics (2002), and prison clinics (2002). By 2010, Iran's treatment efforts in the prisons resulted in the largest population (25,000) of methadone-maintained prisoners in the world (Afkhami, 2009; Farnia, Ebrahimi, Shams, & Zamani, 2010; Tanner, 2013). Other milestones included the opening of the first therapeutic communities in Iran (2001; Mokri, 2002) and establishing the Iranian National Center for Addiction Studies (2003) to conduct addiction-related research and professional education and networking (INCAS, 2007). Recognition of the special needs of addicted women led to the development of special treatment services for women (Dolan, Salimi, Nassirimanesh, Mohsenifar, Allsop, et al. 2011; Movaghar, Langroodi, Ahmadi, & Esmaeili, 2011). More than 60 community drop-in centers also provided a mechanism for outreach and intervention, including delivery of health and psychological services, educational information, and distribution of condoms, syringes, and needles. (Afkhami, 2009).

Since 1997, Addiction treatment in Iran has been provided by the government, universities, welfare organizations, private centers, and non-governmental organizations (NGOs; Farnam, 2005). NGO involvement in the prevention, treatment, and recovery support arenas includes harm reduction and treatment projects, Narcotics Anonymous and other recovery mutual aid efforts, and recovery communities that offer voluntary treatment and long-term recovery support. Some of these efforts were quite remarkable in their growth. By 2005, there were more than 4,900 NA meetings a week in Iran with more than 30,000 NA members (Sayyah, 2006), with NA membership since growing to more than 40,000 members (Maltais, 2011). A 2012 survey revealed that NA meetings in Iran made up 26% of all NA meetings worldwide—more than in any country outside the United States (Lavitt, 2014). By the end of 2007, there were 51 government-sponsored treatment centers and 457 private outpatient treatment centers (Mohammadi, 2007). That same year, a program of mandatory treatment of addiction was initiated through which persons with confirmed addictions were diverted at the point of arrest to residential treatment (Rahimi-Movaghar et al., 2011a,b).

The shift in government policy significantly expanded treatment resources in Iran, but there was growing awareness that more needed to be done to support long-term recovery for individuals and families affected by addiction. These concerns were sparked by problems of low one-year treatment retention rates (Ahmadi, 2002; Ahmadi, Babaee-Beigi, Alishahi, Maany, & Hidari, 2004; Ahmadi & Motamed, 2003; Esmaeli, Ziaddinni, Nikravesh, Baneshi, & Nakhaee, 2014; Rouhani, Kheirkhak, Salarieh, & Abedi, 2012), high post-treatment addiction recurrence rates (63-95%; Mohammadpoorasl et al., 2012; Mokri, 2002; Narimani & Sadeghieh, 2008; Rahimi-Movaghar et al., 2011a; Sadir et al., 2013), limited early improvement in quality of life during treatment (Kobra, Mohammad, &

Alireza, 2012), and high reported rates of intergenerational addiction (Ahmadi, Arabi, & Mansouri, 2003; Ziaaddini & Ziaaddini, 2005). Reports that these outcomes were influenced by a broad range of biological, psychological, familial, social, and economic factors (Roshani, Jalali, Bidhendi, Ezzati, & Mahboubi, 2014) suggested the potential of wrapping medications in a broader framework of ancillary recovery support services (Moeni, Razzaghi, Mahmood, & Pashaeie, 2014) and the potential role of NGOs in providing frameworks of sustained support for long-term addiction recovery and primary prevention (Calabrese, 2007; Razzaghi et al., 1999). NGOs that perform these broader recovery support functions in Iran include Narcotics Anonymous, Jamiat EhyaieEnsani Kongreh 60 (Congress 60), Anjoman Tavalod-e-Dobare (Rebirth Society), Tavalodi Digar (Another Birth), and Rooyesh e Digar (Re-growth). NGO-based addiction recovery support resources are growing with the Islamic Republic of Iran.

The purpose of this study is to provide a detailed profile of one such NGO—Congress 60—that has become one of the most visible addiction recovery communities in Iran. The efforts of Congress 60 have been briefly mentioned in the popular press (Fathi, 2008) and noted in the professional literature (Dahmardehei & Rafaiee, 2012; Figg-Franzoi, 2011; Tabatabaei-Jafari et al., 2014; Tavakoli, 2013; Tavakoli, Sahaf, Ghaffari, Farhoudian, & Hayatbakhsh, 2012; Zarrindast, Sahraei, & Dejakam, 2010), but no detailed profile of Congress 60 has yet been published. This review of Congress 60 will outline its history, structure of governance, treatment philosophy and methods, and its plans for researching and disseminating its methods. This review is drawn from interviews and written communications with the founder of Congress 60 as well as a review of key publications of the organization.

Congress 60

History: Congress 60 is rooted in the personal experience of Mr. Hossein Dezhakam.

> *I'm an electronic engineer by training. I worked in the field of industrial research, design, and repair for 30 years as my addiction to alcohol and then hashish and opium took over my life. I was a hardcore addict for 17 years. I tried many different treatments to cure myself but was repeatedly unsuccessful. In the end, I began playing a game that evolved into the research and trials that I tried on myself. By determining my daily dosage, time of use, and tapering of the drugs, I implemented a plan* [using opium tincture—known in the West as Laudanum] *and to my own disbelief, was successful after an eleven month period to break my physical addiction. It was through this that the DST Method* [pharmacotherapy used in Congress 60] *was invented*. (Dezhakam quoted in White, 2011)

Following self-cure using the DST method, Mr. Dezhakam published an account of his experience in a book, *Crossing the Zone 60 Degrees Below Zero*, and started an NGO, Human Revivification Society (Congress 60) under the motto, 'Let's curb this devastating flame,' to help others seeking addiction recovery. In 1998, the first session of Congress 60 was held in a small room, with eight people attending. Today, more than 20,000 individuals hold membership cards within Congress 60's 38 branches in Iran.

> *Congress 60 is a people-supported, non-governmental organization, active in the treatment and recovery of drug addiction. Its foundation is based on the principal of a revived addict helping fellow addicts who are currently still using narcotics….It has a license from the Ministry of the Interior, and its purpose is to reduce the harmful results of addiction. Congress 60's axis of activities consists of education, prevention, curbing, and guidance in curing addiction. The main objectives of Congress 60 are providing scientific research and practical solutions in*

> *recognizing the relationship between the human psyche and illicit drug dependence and providing a useful method and guidance to drug addicts and their families*. (Dezhakam quoted in White, 2011)

There was early professional resistance to the idea of using opium tincture (OT) in the treatment of addiction, but as the number of people achieving stable recoveries within Congress 60 grew, these attitudes began to change. The Ministry of Health subsequently approved OT in the treatment of opioid addiction, the pharmaceutical companies expanded manufacture of OT preparations, and OT was added to methadone and buprenorphine as choices of pharmacological intervention into opiate addiction in Iran. The *Stadmabroz aba Movad Mokhdar* (Iranian Drug Control Headquarters) supported a pilot project on heroin, opium, hash, and alcohol detoxification with opium tincture for 1,000 persons in Congress60. The pilot is now completed, and results are currently being prepared for publication. Since completion of the pilot, more than 7,000 individuals are being treated with OT using the D.S.T. method within Congress 60.

Governance: Congress 60 is organized into branches, with each branch sharing a similar structure. At present, there are 16 branches in Tehran and 22 branches in other cities of Iran. Congress 60 is organized around six key roles: *Guardian* (founder/director), *Didehban* (14-member parliament of Congress 60 responsible for overall policy and planning), *Marzbans* (seven-person executive teams elected for one year by the branch membership and who assure compliance with branch rules and regulations), *Mosafer* (travelers, those seeking treatment and recovery from addiction), *Hamsafar* (companions, family members, and friends of each traveler who participate in all Congress 60 activities), and *guides* who supervise the treatment process. Each Didehban (supervisor) has responsibility for a specific area of operation, e.g., departments of research, worldview, family, public relations, lady travelers, sports, and guides.

There are three different levels of guide in Congress60: 1) assistant guide, 2) guide, and 3) master guide. Becoming an assistant guide requires six months of recovery (completion of treatment), completion of training classes, and passing a competitive examination. The exam focuses on three primary areas: 1) technical knowledge of drugs and their effects on humans and methods of effective treatment, 2) worldview or spiritual aspects of the recovery process, and 3) moral aptitude of the applicant, which is judged by the management team. The levels of guides are designated by different colors of scarves worn during Congress 60 meetings. The Didehban (14 people), Marzban (250 people), Guides, and Assistant Guides collectively number 800 (500 men, 300 women), all are graduates of Congress 60 (those treated for addiction or family members), and all serve on a voluntary basis.

The central meeting format of Congress 60 is the large workshop. The workshops are delivered mostly by senior members of Congress 60 and sometimes by university instructors and professors who volunteer their time to Congress 60. Each guide has several students that form a *legion* that meet in a public place after these workshops. All members are expected to participate in the discussions. These legions serve as family units within the larger Congress 60 community.

Financing: Funding support for the branches of Congress 60 comes almost exclusively (99.9%) from voluntary donations collected from members at the end of each session, and some branches meet within space provided by government or government-related organizations. Congress 60 has recently established a financial legion within each branch whose purpose is to enable members financially blessed by their recoveries to contribute financial resources to buy land and construct buildings in support of their branch's activities. There are no paid employees of

Congress 60; all roles serve in a voluntary capacity.

Marketing: Citizens of Iran are generally aware of Congress 60 through reports on their efforts that appear in television interviews, newspapers, and magazine stories. This visibility, the lack of fees for its services, and the availability of services regardless of gender, age, religious background, and personal beliefs creates a high demand for participation in Congress 60. Service volume is limited by the capacity of Congress 60 facilities, with some branches unable to accept newcomers because of the current service volume.

Philosophy: The philosophy of Congress 60 is outlined in two books by the founder: *Crossing the Zone 60 Degrees Below Zero* (Dezhakam, 2011a) and *Love, 14 Valleys for Recovery* (Dezhakam, 2011b). Members of Congress 60 use these texts similar to how the "Big Book" of Alcoholics Anonymous and the "Basic Text" of Narcotics Anonymous are used by their members. *Crossing Through the Zone 60 Degrees Below Zero* is used to educate members about the nature of addiction and the method of pharmacotherapy used within Congress 60. *Love, 14 Valleys for Recovery* explores how successful treatment of addiction requires a "full renovation of the individual's beliefs and views of himself, family, society, and the universe" (Dezhakam quoted in White, 2011). Collectively, these works present addiction as an affliction of the body, psyche, and worldview and express the need for treatment that addresses each of these three dimensions.

The theory of addiction that undergirds the physical methods of treatment within Congress 60 is based on what Dezhakam has christened the X system.

> *The X system is an entity that contains all the neurotransmitters and hormones in the human's body. All our spiritual, psychological, emotional, sexual, and physical activities are influenced by this system. To clarify, I should provide a definition for drug addiction in terms of its human physiology. Drug addiction involves a chronic substitution of narcotics, alcohol, and prescription medicine instead of natural opioid substances inside our body—substances like Dopamine, Endorphins, and Serotonin. Having the above definition in mind, we can see that when external substances like drugs and alcohol are imported into the body for a prolonged period of time, the X system is damaged extensively and this in turn causes an imbalance, dysfunction, and disruption within the physical system. Thus, we can name the above-mentioned drugs and alcohol as anti-X, as they cause extensive damage to this vital organization. In fact, understanding the X system and anti-X factors are the important parts of a definitive cure of addiction.* (Dezhakam quoted in White, 2011)

To repair this damaged X system, Congress 60 utilizes opium tincture tapered over a period of 11 months to repair this system and allow people to live free of all opioids and other intoxicants.

Stages of Recovery: The recovery process within Congress 60 is depicted as a three-stage journey. These stages include: 1) using reparative medicine maintenance until treatment is completed at about 11 months, maintenance treatment is ended, and recovery is continued, 2) a drug/medication-free journey of self-discovery involving physical, mental, and emotional rejuvenation and self-knowledge, and 3) a never-ending spiritual process of understanding the order and mystery of our universe. The first two of these journeys are viewed as sufficient to overcome addiction, with the third being viewed as a heightened level of spiritual development and service to others. The Congress 60 Founder described the need for stages 2 and 3 as follows:

> *I can say from personal experience that an addict's world is like a dark prison; one feels trapped inside the experiences of fear, anxiety, rage, humiliation, and lack of identity. In order to march towards light, health, and freedom, the individual must make a move. We call it a journey: a*

> *journey from fear to courage, from anxiety to bliss, from rage to compassion, from humiliation to honor, from sickness to becoming healthy*. (Quoted in White, 2011, p. 15)

Pharmacotherapy: The protocol for use of minimum opium in stage one recovery within Congress 60 is referred to as the DST Method, which involves 14 stages of decreasing dosage of opium tincture. The DST method is a formula by which drugs, alcohol, and addictive medicines are tapered and finally relinquished. In this method, the **D** stands for the Dezhakam coefficient of 0.8 by which dosage is decreased in each step; **S** stands for step, which means maintaining the daily dosage for 21 days; and **T** stands for time, the duration of the overall treatment, which averages approximately 11 months. Daily drug use, the amount of each dosage, and times of pre-treatment drug use must be clarified in this method and then the tapering can begin. Calculations of OT dosage are prepared by one of the trained guides or assistant guides and stamped by an authority representing the Congress 60 branch. This signed slip is then taken to a clinic where the individual is given the prescribed quantity of OT. The goal of the DST method is not the immediate cessation of drug use, but the restoration and repair of the endogenous opioid system through sustained adherence to the DST protocol. Once tapering through the DST method is completed, it is recommended that the individual continue group therapy for a year, at which time, the person may cease participation in Congress 60 or volunteer for one of the many service roles within Congress 60. The DST method has also been adapted for smoking cessation and weight loss within Congress 60 (White, 2012b).

Recovery Education: The core of the re-education process within Congress 60 rests in a series of workshops (more than 23,000 educational workshops a year with an average of 150 participants in each workshop). Each workshop is broken into five sections: male travelers, female travelers, male companions, female companions, and travelers and companions. These workshops convey Congress 60's philosophy of addiction and the 14 Valleys of Recovery. The 14 Valleys in Congress 60 play the same role that the 12 Steps do for members of Alcoholics Anonymous, and the workshops parallel the Step lectures often found in 12-step oriented addiction treatment. The workshops are held for 3 hours, 3 days per week so that members may attend them after working during the day.

Support and Mentorship: Much of the structure of Congress 60 is based on the need to sever relationships that support active addiction and create new relationships, beginning with the companions and guides, that can support long-term addiction recovery. The Congress 60 community is organized around the principal of "*a rehabilitated addict helping other addicts who are still using drugs.*" Such mutual support is conveyed within the larger rubric of activities and rituals that make up community life within Congress 60.

The Recovery Milieu: A major emphasis within Congress 60 is involvement in sports, and more recently, music and the arts. There is a joint meeting for travelers and companions from all branches each week in a large park from 7:00 am to 2:00 pm where members play sports activities in 14 different fields and participate in internal competitions. This ritual and the growing role of sports unfolded inadvertently within Congress 60 due to temporary closure of the central branch by judicial order. During this time, members were forced to meet in the park, where they began to play various sports during their free time. When the judicial order was rescinded 54 days later, the role of sports had already become embedded within the emerging Congress 60 culture. Gradually, other sports were added and annual sports competitions and games such as Golden Eagle Olympics were established. The sport council of Congress 60 conducts annual Olympic sports for the revived drug users who are now competing athletes. There are different sports competitions including soccer, volleyball,

rugby, archery, badminton, table tennis, and traditional body building. Congress 60's archery, rugby, dart, and traditional body building teams have made it up to the National Levels of competition in Iran. The role of sport is part of the larger transformation of identity within Congress 60.

> *When someone wants to introduce himself in a meeting in Alcoholics Anonymous, he says: "Hi, my name is John and I'm an alcoholic. I've been sober for 6 months now." In Congress 60, we say: "Hi, I'm John, a traveler; sporting field is rugby, the name of the guide, Johnson, treatment method DST, revival period 6 months." This goes to show the importance of sports in our NGO; it becomes a part of one's identity."* (Dezhakam, personal communication, 2014)

Music (learning to play an instrument or sing), theatre (performing in a play), and such activities as shared camping among members of various branches are similarly used to facilitate a reconstruction of personal identity and lifestyle within Congress 60. Also of note is the shaping of values and behaviors within Congress 60 related to such issues as order, punctuality, and respect for others, which is similar to that seen in early therapeutic communities.

Advocacy: Congress 60 also affords its members opportunities for community service via public education, participation in policy discussions, and through specific community service projects e.g., annual planting of trees. The intent of these opportunities is as follows.

> *Most people assume that an addict is a person of moral incompetence; he or she is a selfish and carefree individual who does not want to be treated and cured. We want to introduce a concept that says addiction is an illness of body, mind, and worldview and to be successfully treated, many issues must be taken into consideration. We are aiming to challenge the false, futile methods of addiction treatment so as to prevent the vicious cycle of failures, which could harm the will and determination of those seeking redemption from addiction while opening a real, practical path to recovery. We are saying that drug addiction is treatable and curable at any stage. We believe that drug addiction knows no boundaries and no one's children are safe from its destructive fire. We want to alert the public that those who use drugs recreationally today are the prime candidates to become tomorrow's hardcore addicts. We constantly remind the addicts about the grave mistake they have made while simultaneously offering the opportunity to make amends through the courageous act of entering into a treatment and recovery process. Our goal is to create awareness in lawmakers and government officials about the actual nature of drug addiction so that they can make the right decisions that affect the addicts directly.* (Hossein Dezhakam, quoted in White, 2011, p.14)

Research: Congress 60 has collaborated with research scientists on a variety of recent addiction-related studies (Dahmardehei & Rafaiee, 2012; Maarefvand, Ghiasvand, & Ekhtiari, 2013; Mirlashari, Demirkol, Salsali, Rafiey, & Jahahbani, 2012; Namdarpour & Iravani, 2013; Tabatabaei-Jafari et al., 2014; Tavakoli et al., 2012; Zarrindast et al., 2010), but no comprehensive study has yet been conducted of the effectiveness of the methods used by Congress 60. As a result, Congress 60 is currently collaborating with research scientists in Iran on the evaluation of long-term outcomes of the Congress 60 approach to addiction treatment and is involved in a collaborative study with this author to evaluate the adaptation of the DST method for the treatment of nicotine addiction among Congress 60 members.

Discussion

Following the 1979 Iranian Revolution, policies towards widespread prevalence of opioid addiction shifted from one of intense criminalization and repression to more balanced and progressive approaches emphasizing demand reduction, addiction treatment, and recovery support resources (Figg-Franzoi, 2011). The latter included encouragement for the development of recovery support services by non-governmental organizations (Aliverdinia & Pridemore, 2008). The present study profiles Congress 60, a prominent NGO currently providing treatment for drug addiction to more than 20,000 individuals and their families within its 38 branches in Iran. Distinctive features within Congress 60's approach to the treatment of addiction include its integration of biological, psychological, social, and spiritual understandings of addiction and addiction recovery; a unique pharmacotherapy protocol; integration of pharmacotherapy within a vibrant recovery culture; the intense involvement of family and social network members within the treatment and recovery support processes; and a novel approach to the integration of sports, music, and the arts in the reconstruction of personal identity, personal relationships, and daily lifestyle.

Within the philosophy of Congress 60, one finds elements drawn from treatment approaches whose proponents have been involved in vitriolic and highly polarized debates. In the X system theory, one is reminded of the theory of addiction as a metabolic disorder that provided the original rationale for methadone maintenance (Dole & Nyswander, 1967; Dole, Nyswander, & Kreek, 1966) and that has been refined in subsequent research on the neurobiology of opioid addiction (Koob, 2009; Kreek, 2000, 2010; Trigo, Martin-Garcia, Berrendero, Robledo, & Maldonado, 2010). Yet, the method of pharmacotherapy Congress 60 derived from its X system theory uses a different agent (i.e., opium tincture), a substantial but limited (11 months) duration of pharmacotherapy, and a formula-prescribed tapering schedule that decelerates in tandem with increased psychosocial supports.

The use of tincture of opium in tapering persons from a state of opiate addiction to a state of abstinence has been described in the professional literature (Auriacombe et al., 1993, 1994; Chandrasena, 1980; Jittiwutikarn et al., 2004; Nataparan, 2000; Somogyi et al., 2008) and utilized in Vietnam, Thailand, Laos, Vietnam, and Myanmar for detoxification (Ali et al., 2000; Richards & Henry-Edwards, 2002); however, Congress 60 represents the largest and most sustained effort to use tincture of opium in the sustained pharmacotherapy of opioid addiction. The experience of Congress 60 would suggest that opium tincture is a less expensive and culturally acceptable alternative to methadone and buprenorphine in the treatment of opium addiction in Iran (Dahmardehei & Rafaiee, 2012; Mehrjerdi & Zarghami, 2013), but research studies are needed to confirm the long-term recovery outcomes of those treated through the Congress 60 protocol. Worldwide experiments with the use of OT in the treatment of opioid addiction will require greater standardization of OT preparation, experiments to determine optimum OT dosages and dosing schedules as well as comparative studies on maintenance and detoxification with OT, methadone, and buprenorphine (Ali et al., 2000).

One also finds in Congress 60 elements of therapeutic communities, social model alcoholism programs, and addiction recovery mutual aid organizations that rely on a strong sense of community identity, social fellowship, mentoring by others in recovery, a reorientation of personal values and worldview, and the use of recovery literature to guide one's recovery process (White, 1998). The transition into the Congress 60 community is consistent with depictions of the resolution of severe AOD problems as a journey from enmeshment in a culture of addiction to enmeshment in a culture of recovery (White, 1996), with this latter culture filling the vacuum created by the loss of the drug relationship and the rituals and social relationships within which

excessive drug use is so often nested. Congress 60's emphasis on healing family relationships through family involvement in treatment and reconstructing one's social network also addresses two key factors that have been identified as obstacles to recovery in Iran: strained family relationships and continuing involvement with drug-using friends (Rahimpour, Khankeh, Khoshknab, Farhoodian, & Farzi, 2012; Roshani et al., 2014).

Congress 60 provides a novel method of deleting addiction from one's life and alleviating or minimizing cravings that play a role in drug seeking and addiction recurrence. It also offers, through processes of education and mutual support, a means of increasing what Cloud and Granfield (2008) have christened *recovery capital*—the internal and external assets that can be drawn upon to initiate and sustain addiction recovery. Congress 60 combines subtractive and additive processes involving a journey of *recovering from* addiction to a journey of *recovering to* a life beyond addiction. Given the increasing calls to integrate harm reduction and abstinence-based treatment (Evans, White, & Lamb, 2013; Kellogg, 2003; Marlatt, Blume, & Parks, 2001) and calls for more recovery-oriented approaches to methadone maintenance (White, 2012a; White & Torres, 2010), Congress 60 provides a vivid example of how maintenance medication can be wrapped in a rich milieu of psychosocial support for individuals and families seeking support for long-term addiction recovery.

Given the long-enduring and vitriolic debates between advocates of abstinence-based treatment (ABT) and medication-assisted treatment (MAT) for opioid addiction, Congress 60 offers an alternative that integrates key theoretical constructs and practices of both approaches while adding elements found in neither. Studies have found that both ABT and MAT reduce drug craving and drug-seeking behaviors, but may affect different neural mechanisms (Tabatabaei-Jafari et al., 2014). This raises the question of whether combining or sequencing potent ingredients of ABT and MAT may produce outcomes superior to either used in isolation. Studies that have attempted such combinations, including combining methadone maintenance with varied levels of counseling or psychotherapy (Gruber, Delucchi, Kielestein, & Batiki, 2008; McLellan, Woody, Luborsky, & Goehl, 1988; Schwartz, Kelly, O'Grady, Gandhi, & Jaffe, 2011), ancillary social services (McLellan et al., 1998), recovery mutual aid participation (White et al., 2014), or concurrent treatment in a therapeutic community (De Leon et al., 1995; Sorensen et al., 2009), have produced promising but mixed results. Such studies need to be continued using different combinations of pharmacotherapy and psychosocial recovery support in different cultural contexts.

The unique elements that have been combined within Congress 60's approach to addiction recovery warrant extensive and rigorous studies to measure their effects on long-term recovery and to isolate the most potent ingredients within this approach. The purpose of this article is to set the stage for reporting the results of such investigations that are currently under way.

Acknowledgement: Mr. Hossein Dezhakam provided valued assistance in the preparation of this article, and Ehsan Ranjbar provided numerous translations of communications between the author and Mr. Dezhakam.

References

Afkhami, A. A. (2009). From punishment to harm reduction: Resecularization of addiction in contemporary Iran. In A. Gheissari, Ed., *Contemporary Iran: Economy, society, politics* (pp. 194-210). Oxford: Oxford University Press.

Ahmadi, J. (2002). Buprenorphine maintenance treatment of heroin dependence: The first experience from Iran. *Journal of Substance Abuse Treatment*, *22*(3), 157-159. doi:10.1016/S0740-5472(02)00222-2

Ahmadi, J., Arabi, H., & Mansouri, Y. (2003). Prevalence of substance use among offspring of opioid addicts. *Addictive*

Behaviors, *28*, 591-595. doi:10.1016/S0306-4603(01)00260-X

Ahmadi, J., Babaee-Beigi, M., Alishahi, M., Maany, I., & Hidari, T. (2004). Twelve-month maintenance treatment of opium-dependent patients. *Journal of Substance Abuse Treatment*, *26*, 61-64. doi:10.1016/S0740-5472(03)00141-7

Ahmadi, J., & Motamed, F. (2003). Treatment success rate among Iranian opioid dependents. *Substance Use & Misuse*, *38*(1), 151-163. doi:10.1081/JA-120016571

Ahmadi, J., Pridmore, S., Alimi, A., Cheraghi, A., Arad, A., Parsaeyan, H.,…Kianpour, M. (2007). Epidemiology of opium use in the general population. *American Journal of Drug and Alcohol Abuse*, *33*(3), 483-491. doi:10.1080/00952990701301293

Ali, R., Jittiwutikarn, J., Hall, J., White, J., Christie, P., Bochner, F.,…Gray, J. (2000). *Tincture of opium and the use of heroin in Adelaide's Vietnamese community* (DASC Monograph No. 7 Research Series). Australia: Drug and Alcohol Services Council.

Aliverdinia, A., & Pridemore, W. A. (2008). An overview of the illicit narcotics problem in the Islamic Republic of Iran. *European Journal of Crime, Criminal Law and Criminal Justice*, *16*, 155-170. doi:10.1163/157181708X308434

Ataee, M., Jouybari, A., Alavijeh, M. M., Aghaei, A., Mahboubi, M., & Motlagh, F. Z. (2014). Factors related with intention to methadone maintenance treatment among Iranian men addicts. *Life Science Journal*, *11*(4s), 228-231.

Auriacombe, M., Grabot, D., Daulouède, J. P., Vergnolle, J. P., O'Brien, C., & Tignol, J. (1993). Alternatives to methadone maintenance: Laudanum, buprenorphine. In L. Harris (Ed.), *Problems of drug dependence, 1992: Proceedings of the 54th Annual Scientific Meeting The College on Problems of Drug Dependence, Inc. research monograph 132* (pp. 308). Rockville, MD: U.S. Department of Health and Human Services.

Auriacombe, M., Grabot, D., Daulouède, J.-P., Vergnolle, J.-P., O'Brien, C., & Tignol, J. (1994). A naturalistic follow-up study of French-speaking opiate-maintained heroin-addicted patients: Effects on biopsychosocial status. *Journal of Substance Abuse Treatment*, *11*(6), 565-568. doi:10.1016/0740-5472(94)90008-6

Calabrese, J. (2007). Iran's War on Drugs: Holding the line? *The Middle East Institute, Policy Brief, 3*, 1-18. Retrieved April 10, 2014 from http://www.mideasti.org/content/irnas-war-drugs-holding-line?page=16

Chandrasena, R. (1980). Management of opium dependence in a general hospital psychiatry unit. *British Journal of Addiction*, *75*(2), 163-167. doi:10.1111/j.1360-0443.1980.tb02441.x

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use and Misuse*, *43*(12-13), 1971-1986. doi:10.1080/10826080802289762

Dahmardehei, M., & Rafaiee, R. (2012). Opium syrup distribution, limitation and challenges. *Zahedan Journal of Research in Medical Sciences*, *16*(6), 48.

Day, C., Nassirimanesh, B., Shakeshaft, A., & Dolan, K. (2006). Patterns of drug use among a sample of drug users and injecting drug users attending a general practice in Iran. *Harm Reduction Journal*, *3*, 2. doi:10.1186/1477-7517-3-2

De Leon, G., Staines, G. L., Perlis, T. E., Sacks, S., McKendrick, K., Hilton, R., & Brady, R. (1995). Therapeutic community methods in methadone maintenance (Passages): An open clinical trial. *Drug and Alcohol Dependence, 37*, 45-57. doi:10.1016/0376-8716(94)01057-R

Dezhakam, H. (2011a). *Crossing the zone 60 degrees below zero*. Congress 60: Tehran, Iran.

Dezhakam, H. (2011b). *Love: Fourteen valleys for recovery*. Congress 60: Tehran, Iran.

Dolan, K., Salimi, S., Nassirimanesh, B., Mohsenifar, S., Allsop, D., & Mokri, A. (2011). Characteristics of Iranian women seeking drug treatment. *Journal of Women's Health*, *20*(11), 1687-1691. doi:10.1089/jwh.2010.2694

Dolan, K., Salimi, S., Nassirimanesh, B., Mohsenifar, S., & Mokri, A. (2011). The establishment of a methadone treatment clinic for women in Tehran, Iran. *Journal of Public Health Policy*, *32*, 219-230. doi:10.1057/jphp.2011.10

Dole, V. P., & Nyswander, M. E. (1967). Heroin addiction—a metabolic disease. *Archives of Internal Medicine*, *120*, 19-24. doi:10.1001/archinte.1967.00300010021004

Dole, V. P., Nyswander, M. E., & Kreek, M. J. (1966). Narcotic blockade. *Archives of Internal Medicine, 118*, 304-309. doi:10.1001/archinte.1966.00290160004002

Eskandarieh, S., Nikfarjam, A., Tarjoman, T., Nasehi, A., Jafari, F., & Saberi-Zafarghandi, M.-B. (2013). Descriptive aspects of injection drug users in Iran's national harm reduction program by methadone maintenance treatment. *Iran Journal of Public Health*, *42*(6), 588-593.

Esmaeli, H.-R., Ziaddinni, H., Nikravesh, M.-R., Baneshi, M.-R., & Nakhaee, N. (2014). Outcome evaluation of the opioid agonist maintenance treatment in Iran. *Drug and Alcohol Review*, *33*(2), 186-193. doi:10.1111/dar.12112

Evans, A. C., White, W. L., & Lamb, R. (2013). *The role of harm reduction in recovery-oriented systems of care: The Philadelphia experience*. Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services. Posted at www.williamwhitepapers.com.

Farnam, R. (2005). Substance abuse in Iran: A brief overview. Retrieved April 19, 2014 from http://uclaisap.org/slides/dssat2005/Farnam.pdf

Farnia, M., Ebrahimi, E., Shams, A., & Zamani, S. (2010). Scaling up methadone maintenance treatment for opioid-dependent prisoners in Iran. *International Journal of Drug Policy*, *21*, 422-424. doi:10.1016/j.drugpo.2010.03.008

Fathi, N. (2008, June 27). Iran fights scourge of addiction in plain view, stressing treatment. *New York Times*. Retrieved from http://www.nytimes.com/2008/06/27/world/middleeast/27addiction.html?pagewanted=all&_r=0

Figg-Franzoi, L. (2011). *Maslahat*, the state and the people: Opium use in the Islamic Republic of Iran. *Crime, Law and Social Change*, *56*(4), 421-438. doi:10.1007/s10611-011-9326-1

Ghanizadeh, A., Ashkani, H., & Maany, I. (2000). Comorbidity of psychiatric disorders in Iranian treatment-seeking opioid addicts. *Iranian Journal of Medical Sciences*, *25*(1&2), 25-30.

Gruber, V. A., Delucchi, K. L., Kielestein, A., & Batiki, S. L. (2008). A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. *Drug and Alcohol Dependence*, *94*, 199-206. doi:10.1016/j.drugalcdep.2007.11.021

INCAS. (2007). Iranian National Center for Addiction Studies (INCAS). *Iranian Journal of Psychiatry and Behavioral Sciences*, *1*(1), 41-42.

Jittiwutikarn, J., Ali, R., White, J. M., Bochner, F., Somogyi, A. A., & Foster, D. J. R. (2004). Comparison of oral tincture of opium and methadone to control opioid withdrawal in a Thai treatment centre.

British Journal of Clinical Pharmacology, 58(5), 536-541. doi:10.1111/j.1365-2125.2004.02209.x

Kellogg, S. H. (2003). On "gradualism" and the building of the harm reduction—abstinence continuum. *Journal of Substance Abuse Treatment*, *25*, 241-247. doi:10.1016/S0740-5472(03)00068-0

Kobra, L., Mohammad, B. N., & Alireza, S. S. (2012). Quality of life in patients on methadone maintenance treatment: A three-month assessment. *Journal of the Pakistan Medical Association*, *62*, 1003-1007.

Koob, G. F. (2009). Dynamics of Neuronal circuits in addiction: Reward, antireward, and emotional memory. *Pharmacopsychiatry*, *42*, S32-S41. doi:10.1055/s-0029-1216356

Kreek, M. J. (2000). Methadone-related opioid agonist pharmacotherapy for heroin addiction: History, recent molecular and neurochemical research and future in mainstream medicine. *Annals of the New York Academy of Sciences, 909*, 186-216. doi:10.1111/j.1749-6632.2000.tb06683.x

Kreek, M. J. (2010). Overview and historical perspective of four papers presented on research related to the endogenous opioid system. *Drug and Alcohol Dependence*, *108*, 195-199. doi:10.1016/j.drugalcdep.2010.03.003

Lavitt, J. (2014). The crescent and the needle: The remarkable rise of NA in Iran. Retrieved May 28, 2014 from http://www.thefix.com/content/Iran-Narcotics-Anonymous-phonemoneon-Lavitt2099?page=all

Maarefvand, M., Ghiasvand, H. R., & Ekhtiari, H. (2013). Drug craving terminology among opiate dependents: A mixed method study. *Iranian Journal of Psychiatry*, *8*(2), 97-103.

Maltais, K. (2011). 20,000 Iranian addicts gather to celebrate recovery. Retrieved April 23, 2014 from http://www.thefix.com/content/200000-iranian-addicts-gather-celebrate-recovery

Marlatt, G. A., Blume, A. W., & Parks, G. A. (2001). Integrating harm reduction therapy and traditional substance abuse treatment. *Journal of Psychoactive Drugs*, *33*(1), 13-21. doi:10.1080/02791072.2001.10400463

Matthee, R. (2005). *The pursuit of pleasure: Drugs and stimulants in Iranian history, 1500-1900.* Princeton, NJ: Princeton University Press.

McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, *93*(10), 1489-1499. doi:10.1046/j.1360-0443.1998.931014895.x

McLellan, A. T., Woody, G. E., Luborsky, L., & Goehl, L. (1988). Is the counselor an 'active ingredient' in substance abuse rehabilitation? An examination of treatment success among four counselors. *Journal of Nervous and Mental Disease, 176*, 423-430.

Mehrjerdi, Z. A. (2013). Crystal in Iran: Methamphetamine or heroin kerack. *DARU Journal of Pharmaceutical Sciences*, *21*, 22. doi:10.1186/2008-2231-21-22

Mehrjerdi, Z. A., & Zarghami, M. (2013). Maintenance therapy with opium tincture for injecting drug users: Implications for prevention from viral infections. *Hepatitis Monthly*, *13*(4), E8334. doi:10.5812/hepatmon.8334

Mirlashari, J., Demirkol, A., Salsali, M., Rafiey, H., & Jahahbani, J. (2012). Early childhood experiences, parenting and the process of drug dependency among young people in Tehran, Iran. *Drug and Alcohol Review*, *31*(4), 461-468. doi:10.1111/j.1465.3362.2011.00384.x

Moeni, M., Razzaghi, O. M., Mahmood, M., & Pashaeie, T. (2014). Analysis of retention among a sample of opioid

dependents participating in the Methadone Maintenance Treatment Program in Iran. *Journal of the School of Public Health and Institute of Public Health Research*, *11*(3), 55-64.

Mohammad, K. A., Hassan, S., & Dariush, B. (2011). Crack in Iran: Is it really cocaine? *Journal of Addiction Research & Therapy*, *2*, 107. doi:10.4172/2155-6105.1000107

Mohammadi, K. (2007, March 25). Iran's in a fix. *The Daily Mail* (London).

Mohammadpoorasl, A., Fakhari, A., Akbari, H., Karimi, F., Bostanabad, M. A., Rostami, F., & Hajizadeh, M. (2012). Addiction relapse and its predictors: A prospective study. *Journal of Addiction Research & Therapy*, *3*, 122. doi:10.4172/2155-6105.1000122

Mokri, A. (2002). Brief overview of the status of drug abuse in Iran. *Archives of Iranian Medicine*, *5*(3), 184-190.

Movaghar, A. R., Langroodi, Z. M., Ahmadi, S. D., & Esmaeili, M. A. (2011). A qualitative study of specific needs of women for treatment of addiction. *Iranian Journal of Psychiatry and Clinical Psychology*, *17*(2), 116-125.

Namdarpour, F., & Iravani, M. R. (2013). They survey study effect of feedback on the willingness of Holland's theory of interest the spouses of addicts, the quality of life. *Journal of Social Issues & Humanities, 1*(4), 45-48.

Narimani, M., & Sadeghieh, S. A. (2008). A study of the rate and causes of addiction relapse among volunteer addicts seeking help at the Center for the Prevention of Addiction affiliated to the Welfare Organization, Ardabil Province, Iran. *Research Journal of Biological Sciences*, *3*(2), 258-264.

Nataparan, C. (2000). Methadone maintenance and harm reduction in Northern Thailand. Retrieved April 16, 2014 from http://www.drugtext.org/Opiates-heroin-methadone/methadone-maintenance-and-harm-reduction-in-northern-thailand.html

Rahimi-Movaghar, A., Hefazi, M., Davoli, M., Amato, L., Amin-Esmaeili, M., Sahimi-Izadian, E., & Yousefi-Nooraie, R. (2009). Pharmacological therapies for management of opium withdrawal. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD007522. doi:10.1002/14651858.CD007522

Rahimi-Movaghar, A., Khastoo, G., Razzaghi, E., Saberi-Zafarghandi, M. B., Norrozi, A. R., & Jar-Siah, R. (2011a). Compulsory methadone maintenance treatment of severe cases of drug addiction in a residential setting in Tehran, Iran: Outcome evaluation in two and six-month follow-up. *Payesh Health Monitor*, *10*(4), 505-514.

Rahimi-Movaghar, A., Khastoo, G., Razzaghi, E., Saberi-Zafarghandi, M. B., Noroozi, A. R., & Jar-Siah, R. (2011b). Compulsory methadone maintenance treatment of severe cases of drug addiction in a residential setting in Tehran, Iran (1): Process evaluation. *Payesh Health Monitor*, *10*(4), 493-503.

Rahimi-Movaghar, A., Mohammad, K., & Razzaghi, E. M. (2002). Trend of drug abuse situation in Iran: A three-decade review. *Hakim Research Journal*, *5*(3), 171-181.

Rahimpour, R., Khankeh, H. R., Khoshknab, M. F., Farhoodian, A., & Farzi, F. (2012). The evaluation of marital adjustment of the addicts in Isfahan NA groups and their couples. *Iranian Rehabilitation Journal*, *10*(15), 13-17.

Razzaghi, E. M., Rahnimi, A., Hosseni, M., Madani, S., & Chaterjee, A. (1999). *Rapid Situation Assessment (RSA) of drug abuse in Iran (1998-1999)*. Tehran: Prevention Department, State Welfare Organizations, Ministry of Health, I.R. of Iran and United Nations International Drug Control Program.

Richards, I., & Henry-Edwards, S. (2002). *Proceedings Workshop for Pharmacotherapies to Manage Opioid Dependence in Asia, Beijing,*

August 5-7. DASC Monograph No. 12 Research Series. Australia: Drug and Alcohol Services Council.

Roshani, B., Jalali, A., Bidhendi, S., Ezzati, E., & Mahboubi, M. (2014). Study the causes of relapse among Iranian drugs users in Kermanshah. *Life Science Journal*, *11*(1s), 66-71.

Rouhani, S., Kheirkhak, F., Salarieh, I., & Abedi, S. (2012). Quality of life, its early change and retention in MMT programs in Iran: Evidence for policymakers and service providers. *Life Science Journal*, *9*(3), 2633-2638.

Sadir, N., Shojaei, M., Moadab, K., Ababasi, R., Bahrampour, A., & Nakjhee, N. (2013). Outcome evaluation of therapeutic community model in Iran. *International Journal of Health Policy Management*, *1*(2), 131-135.

Sayyah, S. (2006, June 8). Narcotics Anonymous in Iran. *Payvand News of Iran*. June 8, 2006. Retrieved April 16, 2014 from http://www.pavand.com.news/o6/jun/1070.html

Schwartz, R. P., Kelly, S. M., O'Grady, K. E., Gandhi, D., & Jaffe, J. H. (2011). Randomized trial of standard methadone treatment compared to initiating methadone without counseling: 12-month findings. *Addiction*, *107*, 943-952. doi:10.1111/j.1360-0443.2011.03700.x

Shahrbabaki, M. E., Ziaaddini, H., Doost, A. A. H., Ghasemi, M., Shahrbabaki, P. E., Nouri, R. A., & Sharrbabaki, N. S. (2011). Methadone treatment in Iranian opiate addicts: A preliminary report. *Addiction & Health*, *3*(1-2), 53-60.

Shariatirad, S., & Maarefvand, M. (2013). Sanctions against Iran and the impact on drug use and addiction treatment. *International Journal of Drug Policy*, *24*(6), 636-637. doi:10.1016/j.drugpo.2013.04.003

Sharifi, H., Kharaghani, R., Sigari, S., Emami, H., Sadr, M., & Masjedi, M. R. (2012). Common methods to treat addiction in treatment-rehabilitation centers in Tehran. *Iranian Journal of Public Health*, *41*(4), 63-68.

Shekarchizadeh, H., Ekhtiari, H., Khami, M. R., & Virtanen, J. I. (2012). Patterns of pre-treatment drug abuse, drug treatment history and characteristics of addicts in methadone maintenance in Iran. *Harm Reduction Journal*, *9*, 18. doi:10.1186/1477-7517-9-18

Somogyi, A. A., Larsen, M., Abadi, R. M., Jittiwutikarn, J., Ali, R., & White, J. M. (2008). Flexible dosing of tincture of opium in the management of opioid withdrawal: Pharmacokinetics and pharmacodynamics. *British Journal of Pharmacodynamics*, *66*(5), 640-647. doi:10.1111/j.1365-2125.2008.03277.x

Sorensen, J. L., Andrews, S., Delucchi, K. L., Greenberg, B., Guydish, J., Masson, C. L., & Shopshire, M. (2009). Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence*, *100*(1–2), 100–106. doi:10.1016/j.drugalcdep.2008.09.009

Tabatabaei-Jafari, H., Ekhtiari, H., Ganjgahi, H., Hassani-Abharian, P., Oghabian, M. A., Moradi, A,…Zarei, M. (2014), Patterns of brain activation during craving in heroin dependents successfully treated by methadone maintenance and abstinence-based treatments. *Journal of Addiction Medicine*, *8*(2), 123-129. doi:10.1097/ADM.0000000000000022

Tanner, I. (2013, August 23). The lion chases away the dragon: Iran's drug treatment programs are among the world's most progressive. *The Majalla: The Leading Arab Magazine*. Retrieved April 23, 2014 from http://www.majalla.com/eng/2013/08/article55244942.

Tavakoli, M. (2013). The influence of detoxification on the quality of life in substance addicts lives with 40-65 years of age referring to the charity Congress60. *Iranian Journal of*

Ageing, 6(23), 3. Retrieved April 16, 2014 from http://www.yektawebsite.ir/~salmand/search.php?slc_lang=en&sid=1&auth=Tavakoli

Tavakoli, M., Sahaf, R., Ghaffari, S., Farhoudian, A., & Hayatbakhsh, R. (2012). Cost benefit analysis of detoxification in addicts over 40 in human recovery population (Congress 60). *Quarterly Journal of Rehabilitation, 12*(5), 52-57.

Trigo, J. M., Martin-Garcia, E., Berrendero, F., Robledo, P., & Maldonado, R. (2010). The endogenous opioid system: A common substrate in drug addiction. *Drug and Alcohol Dependence*, *108*, 183-194. doi:10.1016/j.drugalcdep.2009.10.011

White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. L. (2011). An addiction recovery community in the Islamic Republic of Iran: An interview with Mr. Hossein Dezhakam, founder, Congress60. Retrieved April 16, 2014 from www.williamwhitepapers.com

White, W. L. (2012a). Medication-assisted recovery from opioid addiction: Historical and contemporary perspectives *Journal of Addictive Diseases, 31*(3), 199-206. doi:10.1080/10550887.2012.694597

White, W. L. (2012b). Smoking cessation within a recovery community: An interview with Hossein Dezhakam, Congress60, Iran. Retrieved April 16, 2014 from www.williamwhitepapers.com

White, W. L., Campbell, M. D., Spencer, R. A., Hoffman, H. A., Crissman, B., & DuPont, R. L. (2014). Participation in Narcotics Anonymous and Alcoholics Anonymous and abstinence outcomes of 322 methadone maintenance patients. *Journal of Groups in Addiction and Recovery*, *9*(1), 14-30. doi:10.1080/1556035X.2014.888883

White, W. L., & Torres, L. (2010). *Recovery-oriented methadone maintenance*. Chicago, IL: Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual disAbility Services and Northeast Addiction Technology Transfer Center.

Zamani, S., Kihara, M., Gouya, M., Vazirian, M., Nassirimanesh, B., Ono-Kihara, M.,…Icikawa, S. (2006). High prevalence of HIV infection associated with incarceration among community-based injecting drug users in Tehran, Iran. *Journal of Acquired Immune Deficiency Syndromes*, *42*(3), 342-346. doi:10.1097/01.qai.0000219785.81163.67

Zarrindast, M.-R., Sahraei, H., & Dejakam, H. (2010). New dimension in drug addiction therapy. *Basic and Clinical Neuroscience*, *1*(4), 67-68.

Ziaaddini, H., & Ziaaddini, R. (2005). The household survey of drug abuse in Kerman, Iran. *Journal of Applied Sciences*, *5*(2), 380-382.



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: Hill, T. & White, W. (2015). Learning from other movements: Gay liberation and recovery advocacy. Posted at **www.williamwhitepapers.com**

Learning from other Movements: Gay Liberation and Recovery Advocacy

Tom Hill and William White[1]

Introduction

For participants of the current recovery advocacy movement, there is much to learn from previous social movements. Lessons of considerable import can be gleaned from the movements that intersected in the 1960s, including the civil rights movement, the black power movement, the new left and anti-war movements, the women's movement, and the gay liberation movement. While all of these are worthy of study, the gay liberation movement holds certain parallels, strategies, and lessons that may be of particular interest. This is due in large part to the societal myths and misunderstandings of both people who have experienced addiction and those with diverse sexual orientations and gender identities. The stigma attached to these groups has often rendered them expendable and, as a result, has forced them into hiding their experiences and identities. Members of the gay community, most prominently Bayard Rustin, played critical roles in the civil rights movement and later drew upon the lessons of the civil rights movement in the same way that members of the recovery advocacy movement are now drawing upon their experience within earlier social movements.

Because the societal stigma and discrimination targeting these two groups have been so severe, they share similarities in the early stages of building a movement of social justice and change. The gay liberation movement – now inclusive of lesbian, gay, bisexual, and transgender (LGBT) lives and identities – currently has 45 years of organizing and movement-building experience compared to the new recovery advocacy movement that emerged in the late 1990s and was formally organized at the 2001 recovery summit in St. Paul, Minnesota. The watershed moment of the gay liberation movement is usually traced to the Stonewall Rebellion that took place in New York City on June 28, 1969. The evening began with a business-as-usual visit to the Stonewall Inn by police from the 6th Precinct arriving to enforce violation of codes prohibiting overt displays of homosexuality

[1] Tom Hill is Senior Associate at Altarum Institute; William White is Emeritus Senior Research Consultant at Chestnut Health Systems.

(dancing, dress codes, etc.). Such visits were usually conducted with a degree of disrespect and harassment. On this particular evening, while certain patrons were being escorted to the paddy wagon, others began to fight back by tossing objects at the police, which soon escalated into an all-out riot. Word of this resistance immediately spread throughout Greenwich Village and soon throngs of community members joined in protest. The skirmish continued for a total of three nights.

Stonewall was not the first act of gay resistance, but its visibility and aftermath forged a precedent and new vocabulary of direct action and civil disobedience for the gay community. In the decades prior to Stonewall, an older generation of gay activists had organized in a quieter and more cautious manner. Stonewall marked the rise of a new and younger breed of activists, who had learned and adopted organizing strategies from the rising movements of the 1960s counterculture and had little patience for the polite picket lines and assimilationist strategies of their community elders. Directly following Stonewall, young gay activists met and formed the Gay Liberation Front (GLF).

Utilizing popular 1960s philosophies of political and cultural revolution, the GLF was an extremely important – if short-lived – part of movement history. The organization was visionary and revolutionary, focusing on a multi-issue agenda that was often difficult to move from highly energized discussion to action. An offshoot, called the Gay Activists Alliance (GAA), soon formed by more impatient GLF members and others who wanted a more practical single-issue agenda focused on obtaining civil rights. This tension between radical and reformist agendas has been a continuum throughout the LGBT movement, with the civil rights reform agenda often taking a lead of prominence, especially over time as radical and revolutionary ideologies have fallen from favor, been forgotten, or become entirely unknown to successive generations.

In the brief space of this article, we will explore some of the early organizing strategies employed by the gay movement as they pertain to our developing addiction recovery advocacy movement. Issues addressed will include (1) creating a visible constituency, (2) changing existing social and political institutions, (3) creating community infrastructure, and (4) building a diverse and inclusive movement. We are releasing this paper as a draft for review by the LGBT and recovery advocacy communities and look forward to feedback and suggestions for revision of both the text and accompanying tables. You may reach us at the following email addresses: Tom Hill Tom.Hill@altarum.org and Bill White (bwhite@chestnut.org).

Visible and Vocal: Coming Out

While the impetus of the new gay movement was initiated in New York City, chapters of both the GLF and GAA quickly spread to cities and college campuses across the country, as well as internationally. To acknowledge the anniversary of Stonewall in an annual commemoration, activists planned the Christopher Street Liberation Day March. This was 1970, when the vast majority of gay people were in “the closet,” careful to avoid public disclosure due to stigma and discriminatory laws. “Come Out!” was a major theme of the march and, as a small group of brave activists made their way up Fifth Avenue from the Village to Central Park, more and more spectators stepped over the curb to join their brothers and sisters in the march. Today, June is celebrated as Pride Month, with many pride marches and events held across the country and internationally.

A successful hallmark of the gay movement has been its emphasis on “coming out of the closet.” It is not possible to build collective power or to challenge stigma when the majority of your constituency is silent and invisible. Silence and secrecy have served to reinforce public opinion that being gay is a sick and immoral choice. Early on, activists urged gay people to come out to family members, friends, co-workers, and neighbors as a means of making them more familiar with and, hence,

sympathetic to, gay people and gay issues. They also emphasized that coming out was an act of personal liberation and that, despite the hardships and barriers, the courage of telling and living the truth was both empowering and liberating. These ideas are highlighted beautifully in the 1978 coming out speech by Harvey Milk: https://www.youtube.com/watch?v=UvZIoZNYTN8

The public campaign of coming out stories became institutionalized in 1988 with the creation of National Coming Out Day. Every October 11th, communities across the country celebrate coming out by hosting storytelling events and creating a safe space for those who are still in the closet to come out. The strategy of coming out has been wildly successful. While it still may not be safe for all gay people to be open about their sexuality, gaining safety is contingent on a critical mass of people who are out of the closet. Further, as young people are coming out earlier in life, their actions and lives are making the closet a thing of the past.

Changing Existing Social and Political Institutions

In addition to addressing the secrecy and invisibility of the gay community and its members, early gay activists needed to address the institutional factors that created the initial need to be closeted. Discrimination and stigma against gay people was present in three basic domains: (1) the legal system (homosexual identity and behavior defined as unlawful), (2) the health and mental health system (homosexual identity and behavior defined as pathological), and (3) the organized church (homosexual identity and behavior defined as immoral and against God). The recurrent theme in each of these domains promoted the idea of the homosexual as a dangerous and threatening element contributing to the breakdown of the moral fabric of a decent society.

Institutional change is an all-consuming effort, involving short-and long-term strategies. An example of an early "win" was the 1973 removal of homosexuality as a diagnosable disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association. This not only enlightened the mental health field about historical attempts to "cure" homosexuality, but lifted the threat of institutionalization and traumatizing treatment procedures, such as aversion therapy, shock treatment, and lobotomies administered to gay people.

Addressing a legal system that has punished gay identity and behavior has been a more involved process, with each strategy hinged to the next for maximum effect. In 1971, Madison, Wisconsin became the first municipality in the United States to enact a Gay Rights Ordinance. Over time, a host of municipalities, counties, and states have followed suit. Establishing this network of local ordinances and state bills laid an instrumental foundation in the repeal of state sodomy laws and legalization of sex between consenting adults. Elimination of state sodomy laws was piecemeal and continued after the Supreme Court case of Bowers v. Hardwick was upheld in 1988. However, the Supreme Court overturned this earlier decision in 2003 in the Lawrence v. Texas case, which invalidated remaining sodomy laws in 14 states. Without the patient work of enacting civil rights ordinances (and fighting attempts to repeal them, as in the successful case of Anita Bryant's 1977 Save the Children campaign to repeal the Dade County, Florida gay rights ordinance) and the repeal of all state sodomy laws, the movement would not be currently enjoying the success of the current US Supreme Court's 2015 decision declaring same-sex marriage legal in and across all 50 states and the District of Columbia.

As advances above proceeded, the remaining stronghold of resistance to the gay movement continued to be Christian institutions. Advances have since been made in many Protestant denominations – notably Episcopalians, Unitarians, Presbyterians, and Lutherans – that ordain LGBT clergy at many levels. In 2003, Episcopal Church created a milestone in the election and appointment of Gene Robinson

as the first gay bishop. There is, however, a large divide between these congregations and a larger number of conservative Protestant denominations that continue to view homosexuality as a sinful and immoral threat to the family and societal fabric. This latter sentiment is echoed by the Catholic Church, which views homosexual behavior as an "inherent evil." The tension within the Catholic Church on this issue is indicated by the approval of gay marriage by popular referendum in Ireland in 2015. That the first country to approve such a referendum occurred in a country whose population is more than 80% Catholic may well mark an international tipping point on attitudes toward the LGBT community. Considering advances and setbacks, obstacles overcome, and hurdles yet to overturn, the LGBT movement has gained tremendous mileage in a relatively short time.

Creating Community Infrastructure

While gay activists were on the frontlines challenging existing institutions, they were also intent on building organizations and institutions in their own communities. Prior to Stonewall, there were strong and stable community networks, kinship systems, and cultural norms that were established in the secrecy of gay bars and clubs and extended out into gay neighborhoods of urban areas. Using these networks as a foundation, gay activists realized the need of building community infrastructure in order to address areas in which they were not being served or supported by the larger community.

The 1970s witnessed a proliferation of activity in the building scaffolding to support the gay community. In the wave of feminism and sexual revolution of the times, lesbian health clinics and gay men's STD (sexually-transmitted disease) clinics sprouted in urban areas and university campuses across the nation. Legal clinics were formed, gay therapists were identified, and youth and elderly programs were established. Peer-led support groups were organized to address such issues as coming out, parenting, and establishing a health gay identity. Community centers were established as safe places to meet others, seek services and support, engage in political organizing, and simply hang out with other gay people. Gay political groups formed to support election campaigns of gay leaders and allies and to support social clubs, arts organizations, and professional guilds. And while gay bars and clubs flourished, so did the development of gay-specific recovery mutual support groups. The first gay-identified "special interest" meeting of Alcoholics Anonymous began in Washington, DC in 1970 which spawned what is now a vast international network of gay 12-step groups and meetings.

The importance of building this infrastructure cannot be overstated. The establishment of this service and support capacity proved invaluable when the AIDS epidemic hit the gay community in the early 1980s. Considering that the movement was still in relative infancy, the public and political response to AIDS was laden with stigma and shame, leaving leaders of the LGBT community to respond on their own. A network of lesbian and gay doctors, nurses, therapists and social workers, educators, lawyers, and lay people were able to organize support in both professional and volunteer capacities. Service organizations such as Gay Men's Health Crisis and People with AIDS Coalition provided infrastructure, built on the foundation of previous community action. Of important historical note is the notion of solidarity within sectors of the community. Lesbians, largely unaffected directly by AIDS, responded in full force as volunteers, advocates, and activists.

Drawing on lessons and strategies of direct action groups like the Gay Activist Alliance, new organizations took political action to ensure care and support for those living with AIDS, promote the development of effective treatment and research protocols, and promote prevention efforts aimed at curtailing further infections. Many of these early attempts culminated in the establishment of ACT UP (AIDS Coalition to Unleash Power) in New York City in 1987. ACT UP groups, fanning out across the

country, gave the community a vehicle through which to vocalize their outrage, challenge the mixed stigma of "AIDS and gay," advocate for medical treatment and social services, and challenge policy and funding arenas. The Silence=Death campaign, unleashed by an ACT UP affinity group called Gran Fury, urged a second kind of coming out and ushered in a host of people with AIDS and their allies who were adept at putting a human face on AIDS.

ACT UP was also instrumental in spawning a host of spin-off direct action groups that addressed the misogyny, homophobia, and heterosexism that fueled the stigma of AIDS. Groups like Queer Nation, Women's Health Action Mobilization (WHAM!), Lesbian Avengers, Women's Action Coalition (WAC), and Youth Education Life Line (YELL) all formed during the period of ACT UP's heyday, creating a web of activist support and a collective outrage.

Building a Diverse, Inclusive, and Sustainable Movement

Because the gay liberation movement grew out of and was aligned with other social justice movements of the 1960s, many early gay activists developed a sophisticated analysis of power and oppression. For lesbians and people of color, this sophistication came through personal and collective struggle against patriarchal power and male, white privilege. Early on, many gay, white men were on a steep learning curve as they learned the "new etiquette," which required both awareness of and willingness to adopt models of shared power and leadership. As questions concerning gender, race, and ethnicity were processed within the movement, struggling through conflict became the norm. In many instances, white gay men were encouraged to step aside in order to make leadership and spokesperson opportunities available to lesbians and people of color.

One of the manifestations of this struggle resulted in a critique of language, particularly around the word "gay" as a fixed and static identity. Many lesbians, informed by feminist consciousness, felt that gay was particularly male-identified and needed to be preceded by the word "lesbian" in order to be fully inclusive. Hence, "lesbian and gay." Later, bisexuals of both genders, felt that their experience of sexual orientation should not be confined to an either/or status, and advocated for "lesbian, gay, and bisexual." Finally, members of the transgender community, whose experience spanned all definitions of sexual orientation, but focused more closely on gender identity, were responsible for the addition of "lesbian, gay, bisexual, and transgender" or LBGT. The language debate has not stopped there and continues with a host of additions and alternatives that will likely continue as the movement evolves.

The struggle to build an inclusive movement has not always been an easy one. Undertaking a comprehensive analysis of power and oppression has demanded the LGBT community closely examine intersections in which issues of homophobia and heterosexism converge with sexism, racism, and transphobia. Protocols of inclusion have often resulted in community discourse centered on dismantling hierarchies of power within the community that are based on myths, biases, and assumptions. Particular demand for transgender inclusion has created political rifts, based on the profound public stigma experienced by the transgender community. In particular, some lesbian, gay, and bisexual activists have advocated for political strategies that initially omit the transgender community, with a vague promise of an "add-on" inclusion following a political win.

The quest for honoring the diversity of LGBT experience has often resulted in a complex web of communities, groups, and organizations. This big umbrella, while creating a rich multi-cultural experience, has not come easily. The commitment to leveling the playing field to incorporate the experience of gender, race, ethnicity, and class has not always been shared unanimously. Despite the difficulties, the LGBT movement has made great strides and contributions to building a movement

that includes the experience of everyone and consciously makes space for all queer realities.

Potential Lessons for the Recovery Advocacy Movement

As noted in the introduction, we believe the remarkable advances of the LGBT community since Stonewall are filled with lessons applicable to the recovery advocacy movement. In this section we will explore some of those lessons.

Movement Identity and Boundaries

A central task of all social movements is to carefully define and manage the boundaries of movement inclusion/exclusion. As we noted above, the process through which a gay liberation movement (a G movement) became the LGBT rights movement was not an easy one. The recovery advocacy movement faces and continues to face challenges related to its boundaries of inclusion. Critical decisions included early assurance that the movement would 1) be a "coat of many colors" (conscious diversity of representation across gender, generations, sexual orientations and gender identities, ethnicity, etc.), 2) represent multiple pathways and styles of recovery, and 3) include family recovery experience—including families who had lost a loved one to addiction. Questions about the boundaries of inclusion (e.g., representation of issues related to process addictions, and representation of recovery experiences/needs for related conditions such as trauma or mental illness) and the degree of collaboration with allied rights movements will continue to face the recovery advocacy movement. The challenge will be to chart a path between narrow exclusiveness at one extreme and identity diffusion and loss of mutual identification and mission clarity at the other extreme. This is not a point-in-time movement task but an ongoing process that will require careful forethought and ongoing evaluation. For example, a presentation at the 2013 meeting of the Association of Recovery Community Organizations noted the progress of inclusiveness, but also called for a renewed focus on those not reached in the first wave of mobilization, e.g., Hispanic and Asian communities, young people in recovery, families and children positively affected by addiction recovery, and those who had lost a family member to alcohol and other drug use/addiction.

Movement Strategies: Contact (Coming Out), Protest, Educate, Advocate, Legislate

Effective social movements employ multiple social change strategies, but movements to confront stigma rest to a great degree on the centrality of contact strategies. The LGBT rights movement demonstrates the value of sequencing and combining multiple strategies for social change. Mass protest, public and professional education, advocacy at personal and systems levels, and legal redress and legislative initiatives all played important role in the advances of the LGBT movement, but, in retrospect, all of these strategies paled in comparison to the effects of the personal decisions of legions of LGBT people to come out. Advances of the LGBT movement in the U.S. grew in tandem with the number of citizens who reporting knowing an LGBT person in their family or social network. The recovery advocacy movement is also employing varied change strategies, but its ultimate success may rest on the number of recovering people in the U.S. who choose to disclose this status in their personal interactions and at public levels.

What is unique about the recovery advocacy movement is the tradition of anonymity within 12-Step recovery programs. That historical tradition required, and continues to require, education about the distinction between disclosing one's membership in AA or another 12-Step fellowship and disclosing one's recovery status at the level of press, as well as assuring that the spirit of anonymity as a spiritual principle (protection against ego

inflation; expression of personal humility) is maintained through one's advocacy activities. A major achievement of the recovery advocacy movement to date has been to successfully launch this movement with respect for the traditions of 12-Step programs and to carefully separate the recovery advocacy movement from movements focused exclusively on recovery mutual aid.

Silence=Death

Social movements live and die based in the degree to which they can instill and sustain a sense of urgency for change. Nothing galvanized the gay community as did the devastation of the early AIDS epidemic. It wasn't just the lethality of AIDS at that point in history, it was the growing recognition that the historical silence and invisibility of the gay community had contributed to the conditions that were at the root of the inadequate national, state, and local responses to the AIDS crisis. One wonders about the parallels between early AIDS deaths and the presently escalating opioid overdose deaths. What portion of the latter losses is fed by the silence of affected families and the public silence of people in recovery? Two of the most important milestones in the recovery advocacy movement are the decision by a vanguard of people in recovery to step out of the cultural closet in which they had been hidden and the inclusion in the recovery advocacy movement of families who have lost a loved one to addiction. Stories from both sources are important in conveying the addiction vulnerability of all families and the importance of access to affordable, high quality treatment and recovery support services.

Sustaining urgency within a culture with a very short attention span is a major challenge confronting the new recovery advocacy movement. Every addiction-related tragedy is an opportunity for personal recommitment and renewed efforts at community mobilization.

The Power of Story (Coming Out)

The ultimate antidote to stigma lies within the public stories of the stigmatized. We have extolled the power of coming out in two earlier blogs. (Click here and here). Among the points we raised in those blogs were the following:

"The stigma attached to addiction is more than a social designation of difference; it is an imposed stain of shameful difference. This ascribed defect is not visible; its application is contingent on shared or discovered knowledge of one's addiction/recovery status. Recovery concealment is a stigma avoidance strategy; recovery disclosure can be a powerful stigma protest strategy."

"Recovery disclosure is not an all or none proposition; it often unfolds incrementally based on levels of intimacy and safety and may vary from no disclosure (complete concealment) to minimal disclosure (status of recovery) to maximum disclosure (details of recovery story)."

"Recovery disclosure can occur as a personal act, but it can also occur as a collective act, as happens each year in public recovery celebration events in the U.S. and in other countries. Rituals of collective disclosure can exert a profound influence on recovery identity and embolden social disclosure of recovery status outside of such events."

"Disclosure of recovery status can lead to increased levels of self-acceptance (i.e., diminished levels of shame, decreased feelings of imposterhood from "passing," liberation from secret-keeping, and lost fear of discovery) and imbue positive feelings from the belief that disclosure is an act of service that will help carry a message of hope to others and help alter public attitudes and policies towards addiction and recovery."

What the LGBT rights movement provided were public role models and a language for private story construction and public storytelling. The recovery advocacy movement is performing these same functions. Story and storytelling have been

and will continue to be the foundations of both movements.

Importance of Symbolic Firsts

The progress of movements to breakdown stigma and discrimination can be measured by the arrival of symbolic firsts in all sectors of community life. *Symbolic firsts* inspire and elevate by challenging culturally-defined and self-defined boundaries of what is possible based on one's social and personal circumstances. Such heroic figures can play critical roles in the processes of intrapersonal, interpersonal, and social change as indicated by the history of the civil rights movement and the women's, LGBT, and disability rights movements. When people who fill culturally iconic roles but also share a concealable stigma come out with their personal stories, it creates the cognitive dissonance (contradiction between prevailing attitudes and one's affection for the culturally iconic person). Such collective dissonance is the precursor to shifts in social attitudes and social policies that if successful, reach a point of saturated inclusion in which the "first status" in major cultural arenas is no longer newsworthy.

The social stigma and shame attached to LGBT and addiction status made it difficult for early pioneers in both movements to wrap themselves in the moral authority of the civil rights and women's movements. That challenge added greater pressure on those who filled the symbolic first roles within the LGBT and recovery advocacy movements.

If one compares the progress of these two movements as displayed in Table A in the Appendix, it is evident that the LGBT movement has made far more progress in the symbolic firsts area than has the recovery advocacy movement. The progress of both movements can be tracked by the evolution in public disclosures of symbolic firsts occupying fringe cultural roles (e.g., musicians, artists, athletes, actors, and entertainers) to centrist roles (e.g., doctors, nurses, lawyers, scientists, religious leaders, business leaders, and labor leaders). Stigma reduction efforts have been successful when symbolic firsts in the latter roles are so common as to be no longer newsworthy.

Recovery as Liberation

The conceptualization of the recovery advocacy movement as a liberation movement is metaphorically powerful, and the personal experience of recovery adds moral authority to advocacy efforts. The coming of age of the LGBT community was conceptualized early on as a liberation movement, with parallels drawn to other important social movements of its time. The recovery advocacy movement is also best viewed as a liberation movement—personal liberation from the state of addiction and collective liberation from social conditions that have contributed to addiction as well as constituted obstacles to recovery initiation and long-term recovery maintenance.

Styles of Activism

Successful social movements embrace diverse styles of activism. The LGBT movement, as does the civil rights and women's movements, vividly illustrates the varieties of activism that make a successful social movement. Such varieties span varied types of participation (e.g., from public disclosure of one's story to acts of private philanthropy), varied intensities of participation (from volunteer to full-time paid roles), and varied durations of involvement (from months to decades). Effective social movements require both sprinters and long-distance runners.

Stages of Social Movements

Social movements unfold and mature in predictable stages. There are remarkable parallels between the stages of the LGBT rights movement and the recovery advocacy movement. Some of the more important of these stages are the following.

Consciousness Raising Although the ignition of the LGBT rights movement is often placed within a spontaneous collective

act (Stonewall), a period of heightened consciousness raising both preceded and followed this event. Social movements incubate within conversations by people with shared experience, and it is within such conversations that the vision of a social movement and commitment to such a movement are born and repeatedly refined and renewed. The most important way to speed the development of a social movement is to create and expand the space where such conversations can occur. A small project (Recovery Community Support Program) within the Center for Substance Abuse Treatment in the late 1990s played an important role in bringing recovery advocates from around the country together so that such conversations could be elevated to a national level. That early networking was a critical stage in the rise of a new recovery advocacy movement in the U.S.

Kinetic Ideas, Words, and Images Movements whose time is right find kinetic (capable of eliciting action) ideas, words/phrases, and symbolic images rising from conversations that mark a break from the past and constitute an early stage of movement branding. This early stage is critical if the birth of the movement is to succeed. Great care must be taken in naming the movement, rejecting stigma-laden language from the past, and forging a new language of liberation. Nearly every modern social movement of note understood this simple lesson: Language matters. Changes in the language of discourse constitute an important goal, a critical tactic, and an evaluation benchmark for social movements.

Formalization of Vision and Tactics Discussions of vision and tactics will inevitably reveal different degrees of radicalness in movement vision, goals, strategies, and tactics. Such varied opinions are inevitable and will eventually spawn organizational diversification. Such diversification is often used as evidence of movement failure (e.g., characterized as schisms and splintering) by the larger culture, but is in fact a normal and inevitable stage of successful social movements. There may be later needs for structural consolidation of the movement, but the growth or movement organizations early on is desirable and inevitable to draw the circle of inclusion as broadly as possible and to give focused attention to multiple issues of import.

Infrastructure & Leadership Development Effective social movements require structures to facilitate communication and action, but they may or may not be characterized by a single charismatic leader. In contrast to the civil rights and women's movements, which had clearly identified national leadership, the LGBT rights movement and the recovery advocacy movements demonstrated that effective social change movements can be initiated and sustained without dominant charismatic leadership. Both of the latter movements have consciously sought to maintain a highly decentralized organizational structure, with an emphasis on grassroots action and decentralized and rotating leadership.

There is a risk within social movements launched by the historically disempowered that internalized stigma will be acted out within the dynamics of the movement such that anger and resentment gets discharged within the movement rather than at the external conditions which are their original source. Awareness of these dynamics can blunt their effects, just as conscious efforts at mutual support can ameliorate them. Such dynamics can also lead to the scapegoating of emerging organizational leaders, suggesting the need to build in special protections and supports for movement leaders at all levels.

The greater the intensity of hatred towards a marginalized group, the greater the potential for martyrs within the movement's history, often as a product of schisms within the movement or extreme fringes of the cultural backlash to movement successes, e.g., the assassinations of Martin Luther King, Jr. and multiple civil rights workers, Malcolm X, Harvey Milk, and physicians working at abortion clinics.

Mass Mobilization & Backlash Management

No successful social movement has succeeded without weathering a backlash movement (or a series of such movements across the stages of social change.) Such episodes of backlash have been evident within the history of the LGBT movement and will be experienced within the recovery advocacy movement when the movement threatens key institutional interests. Backlash preparation and responses are essential stages of movement protection.

Institution Building

Successful social movements spawn new indigenous institutions that create space within local communities through which the goals of the movement can be actualized. (See Table C in Appendix)

Cultural Development

Successful social movements aimed at reversing social stigma require cultural rebranding—the forging of new language, literature, values, symbols, music (anthems), and new rituals of collective self-affirmation. Examples of such cultural development within the LGBT and recovery advocacy movements are displayed in Table D in the Appendix.

Movement Maturation, Growing Pains, & Celebration

All successful social movements experience growing pains as they beyond the early consciousness raising and cultural/political mobilization stages into building the structures and strategies to achieve long-term movement goals. Generational tensions within the movement and heated debates over goals, strategies, and tactics are common, including fears that the spirit of the movement is being lost as these new structures and strategies are being institutionalized. Rather than a sign of a weakened movement, such tensions are healthy and help assure authenticity of representation and help restrain forces of professionalization and commercialization. Vitriolic debates and strained relationships are often glossed over when the later history of the movement is recorded. Social movements are messy. When successful social movements are viewed in the hindsight of history, they can look like exceptionally well-organized and pristine affairs. We know from participating in such movements that the reality is far more primitive. Social movements are pressure cookers that can bring out the best and worst in people. They can be ennobling, but they can also, without considerable care, leave one's personal life in tatters.

Social Movement as Mini-Movements

Successful social movements are most often a collection of movements aimed at different social institutions. The LGBT and recovery advocacy movements launched strategic efforts aimed at such arenas as government, law and regulatory policy, the military, business and industry, health care, housing, educational institutions, religious institutions, the media, sports, and entertainment. It is only by initiating and sustaining change within the primary institutions or creating alternative institutions that social movements can effectively achieve their goals. Movement leaders can critique their progress by the degree to which such influences have been affected and where such work remains to be done. Soliciting and developing indigenous leaders within these institutions is critical to movement success.

Changing Law/Policy/Regulation

Historically, social stigma, whether in the LGBT or addiction recovery arenas, became deeply ingrained within discriminatory laws and practices. An essential stage in the LGBT rights and recovery advocacy movements (and multiple movements that preceded them) is

the dismantling of this machinery of discrimination and creating legal/regulatory protections against such discrimination. Some of the milestones in this area within the LGBT and recovery advocacy movements are displayed in Table E in the Appendix.

Mutual Identification and Movement Themes

Social movements face the challenge of forging themes that create and sustain mutual identification among its primary constituents. This is critical for achieving consciousness raising and mass mobilization. But, in terms of influencing broad social attitudes and policies, social movements must also strike themes with which the mass populace can identify. The latter is crucial to decreasing social distance between marginalized and mainstream populations and in breaking down the "we-they" dichotomy that feeds social demonization and discrimination. Meeting both of these needs requires that themes and methods of movements evolve over time, with continuing sensitivity and attention to both goals. The militancy of the early LGBT movement helped launch the movement and address the urgency of the AIDS epidemic just as later stages of this movement incorporated broader themes (fairness, tolerance, equality) and images (e.g. beloved LGBT figures, gay family life) that drew increased capacity for identification from the larger culture.

Duration of Movements

Most successful social movements (e.g., civil rights movement, women's movement) span decades if not centuries of sustained effort, but some movements affect change over a remarkably short period of time. What is distinctive about the LGBT rights movement is the speed of its achievements compared to the parallel movements that preceded it. That success may be rooted in cumulative social effects (rights movements may be building on each other over time), to the life and death stakes imposed by the AIDS epidemic, and to specific strategies employed by the LGBT movement. Given the comparative speed of this change, all recovery advocates would do well to become students of the history of the LGBT movement.

There is always danger of premature termination of movement activities in belief that major movement objectives have been achieved. The recovery advocates of the 40s, 50s and 60s believed much of their work had been achieved with the passage of landmark legislation in the early 1970s. With the subsequent wave of public funding, many advocates were swept into board and staff positions of newly opening alcoholism treatment centers—a trend that marked a diminishment of public education and political advocacy activities and the subsequent restigmatization, demedicalization, and intensified criminalization of AOD problems in the 1980s that then set the stage for the rise of a new recovery advocacy movement.

Movements and Media

Influencing the major media is a central strategy for most successful social movements. Power must be amassed to turn the media's perpetuation of stigma and discrimination as a reflection of the larger culture to an instrument for the transformation of that culture and the elimination of stigma and discrimination. We have addressed this challenge in an earlier paper, noting the media's propensity to overdramatize and demonize addiction stories, fail to tell the recovery story, convey recovery as an exception to the rule, and convey recovery as a personal story rather than as a broad social phenomenon affecting family, community, and cultural health. The LGBT movement faced similar challenges, but found a way to move much of mainstream media from portraying only the most lurid images of LGBT life to portraying more balanced stories and images of LGBT life and the challenges faced by members of the LGBT community. Again, symbolic firsts played an important role in setting the stage for this

transformation in how the media covered LGBT issues.

Historical Consciousness

There is a point within the mass mobilization of social change movements marked by a rising historical consciousness—a heightened sense of a collective identity as "a people" with a distinctive history. Signs of such consciousness include interest in early movement organizations, leaders, and events. As the LGBT movement unfolded, interest grew in the earlier work of such organizations as the Society for Human Rights, the Mattachine Society, and the Daughters of Bilitis. As the recovery advocacy movement blossomed, interest grew in the history of early recovery mutual aid societies and in the early work of the National Council on Alcoholism and Drug Dependence (NCADD) and the Society of Americans for Recovery (SOAR). Such historical interest is both a way to honor earlier efforts and a way to mine lessons from these earlier attempts at social reform.

Movement development can be, in part, charted by the number of books available on the history of movement members and their efforts. Compare, for example, books available on the history of the LGBT rights movement and books available on the recovery advocacy movement (Table F in the Appendix). As can be seen in Table F, the recovery advocacy movement has yet to see itself as worthy of historical critique to the extent that the LGBT rights movement and earlier movements have.

Experience/Voices of Family and Children

Family- and child-focused themes are extremely powerful tools for breaking down social stigma. While some long-tenured leaders lament the loss of the LGBT movement's radicalism and express concerns marriage equality reflects an assimilationist goal, culturally dominant attitudes toward the LGBT community began to rapidly shift in the U.S. when images and stories of LGBT families--couples and their children--began to replace the media's preoccupation with the most inflammatory images of gay America. The formation of Parents and Friends of Lesbians and Gays (PFLAG) in 1972 has continued to articulate the affirming perspective of family members and allies throughout the movement. Some recovery advocacy leaders have similarly suggested the need to begin to frame the recovery story in America as a story affecting families and children.

The "face" of the movement must expand beyond recovering individuals—whom the public tends to view as self-centered and self-indulgent due to the media's obsession with self-destructing celebrities—to the image of families in recovery. The demonization of the person affected by addiction will continue until we positively (and visually) nest that person in the context of family, friends and community. In that same vein, it is also time we explored more consciously an expanded role for children within the movement—a potential that was critical within the respective histories of the civil rights and LGBT rights movements.

Capitalizing on Generational Change

Generational change can be a powerful force in advancing social movements. Both the LGBT and recovery communities have the youngest people in history declaring their status at private and public levels. Their opening is speeding changes in attitudes among their peers and the larger culture and they constitute what will be a new generation of leaders to carry these movements forward into the field—at the same time those aging leaders of the backlash movements are fading from the scene without a new generation of leaders in site.

Summary and Conclusions

The LGBT rights movement is one of the most successful social movements in history as judged by the speed in which it has

elicited broad changes in cultural attitudes and policies of import to the LGBT community. This essay compared the LGBT rights and recovery advocacy movements for potential lessons the latter movement might draw from the advocacy efforts of the LGBT community. If the recovery advocacy movement continues to culturally and politically mobilize people in recovery and their families and allies and to draw upon the experience of other social movements, we are likely to see the following in the coming years:

- A more conscious effort on the part of recovery advocates to extract lessons from the civil rights, women's liberation, disability rights, LGBT rights, and other successful social reform movements.
- The expansion of symbolic firsts in recovery beyond the arenas of music, entertainment, and sports to such arenas as government, business, science, medicine, and religion.
- The mass mobilization of families affected by addiction/recovery, including families who have lost a family member to addiction (e.g., public story elicitation).
- The increased portrayal of recovery as a family achievement that produces profound effects on family relationships and family health.
- Continued growth in local and national recovery celebration and recovery advocacy events.
- Legislative milestones that mark a shift from punitive to public health responses to alcohol and other drug problems, including the dismantling of legal barriers to full community participation of people in recovery, e.g., in such arenas as housing, employment, education, health care, voting, and other areas of civic participation.
- The continued growth of local recovery support institutions (beyond addiction treatment and recovery mutual aid fellowships) and growth of recovery advocacy organizations addressing specialty issues related to housing, education, employment, leisure, and social networking.
- The growth of recovery social clubs (beyond 12-step clubhouses) and the emergence of "recovery neighborhoods" within large urban communities.
- Growing regional networks of recovery community centers as social, service, and organizing hubs.
- The proliferation of micro-businesses created by and for recovering people that will afford marginalized people in recovery opportunities to acquire new skills and participate in the licit economy.
- More fully developed portrayals of people in recovery within the popular media

(film, television, theatre, and literature), including the portrayal of the diversity of people living in long-term recovery and the varieties and styles of long-term recovery.

- Growing interest in the history of the recovery advocacy movement via new historical treatises, memoirs, and documentary films.
- Growing sophistication in advocacy/activism, issue articulation, and mobilization strategies.
- Tensions within the recovery advocacy movement on the boundaries of movement inclusion (e.g., range of inclusion of people recovering from other compulsive behaviors) and definitions of recovery.
- The abandonment of professionally stigmatizing language within healthcare and specialty sector addiction treatment (e.g., abuse/abuser, alcoholic/addict, and

clean/dirty) as a result of successful recovery advocacy efforts.

- The establishment of recovery as a legitimate research and clinical specialty within the alcohol and other drug problems arena.
- Development of sophisticated strategies to fund recovery advocacy efforts, including expanded donor base (large and small gifts) from recovery community members, corporations, and foundations.
- Advanced awareness of factors that impact recovery organizing and outreach, such as gender, sexuality, culture, race, class, and histories of trauma and incarceration.
- Continued capacity-building and infrastructure development in recovery community organizations, institutions, cultures, and the networks that connect them.

We look forward to hearing from recovery advocates around the country and in other countries about the lessons the recovery advocacy movement can draw from earlier social movements. You may reach us via the following email addresses: Tom Hill Tom.Hill@altarum.org and Bill White (bwhite@chestnut.org).

Acknowledgements: Thanks to the many friends and colleagues who offered suggestions for completing the tables in the appendix. Thanks to Rita Chaney for helping with final edits and proofing.

Appendices

Table A: Symbolic Firsts within LGBT and Recovery Advocacy Movements

Area of Cultural Breakthrough	LGBT Rights Movement	Recovery Advocacy Movement
Symbolic Firsts –Medicine and Science	Dr. Lawrence Mass Astronaut Sally Ride	Dr. LeClair Bissell Dr. James West Dr. David E. Smith Dr. Garrett O'Connor Dr. Kevin McCauley Astronaut Buzz Aldrin
Symbolic Firsts—Business	Tim Cook / CEO of Apple Computers John Browne / CEO of BP Oil Company Robert Hanson / CEO of American Eagle Outfitters Joseph Evangelisti / CCO of JP Morgan Chase Tim Gill, CEO of Quark, Inc,	R. Brinkely Smithers (Deceased), Christopher D. Smithers Foundation James Kemper (Deceased), Kemper Insurance Don Fertman, Subway Chief Development Officer John Tyson, CEO Tyson Foods John Silverman, Chairman and CEO Silver Seal Corporation
Symbolic Firsts—Politics & Government	Innumerable (Partial List) Nancy Wechsler & Jerry DeRieck (First openly lesbian and gay elected officials—Ann Arbor, MI City Council, 1972) Kathy Kozachenko Elaine Noble Allan Spear Harvey Milk Dale McCormick Sherry Harris Althea Garrison Openly LGBT Members of U.S. Congress include: Barney Frank, Steve Gunderson, Tammy Baldwin, Jim Kolbe, Gerry Studs, Jared Polis. Michael Huffington, Mike Michaud,	Governor/Senator Harold Hughes Mrs. Betty Ford Congressman Wilbur Mills Congressman Jim Ramstad Congressman Patrick Kennedy Michael P. Botticelli, Director, White House Office of National Drug Control Policy Texas Governor Ann Richards Marty Walsh, Mayor of Boston

	David Cicilline, Sean Patrick Maloney, Mark Takano, Mark Pocan, Krysten Sinema, Gerry Eastman Studds Megan Smith (Chief Technology Officer of the U.S.) Deborah Batts (Federal Judge) Michael P. Botticelli, Director, Office of National Drug Control Policy Pamela Hyde, SAMHSA administrator James Hormel (ambassador to Luxemborg) Roberta Achtenberg (U.S. Commission on Civil Rights) Tom Ammiano (CA State Assembly) Tom Duane (NY State Senator) Deborah Glick (NY State Assembly)	
Symbolic Firsts—Sports	Billie Jean King (Tennis) Renee Richards (Tennis) Martina Navratiolova Greg Louganis (Diving) Tom Daley (Diving) Diana Nyad (Swimming) **Brian Boitano (Skating)** **Blake Skjellerup (Skating)** Michael Sam (Football) David Kopay (Football) Sheryl Swoopes (Basketball) Jason Collins (Basketball) John Amaechi (Basketball) Jim Bouton (Baseball) Dave Pallone (Baseball) Caitlyn (Bruce) Jenner (Olympics) Bob Paris (champion bodybuilder) Fred Rosser (Darren Young, Wrestling)	Darryl Strawberry (Baseball) Josh Hamilton (Baseball) John Lucas (Basketball) Chris Herren (Basketball) Vin Baker (Basketball) Ray Lucas (Football) Andre Agassi (Tennis) Lucille O'Neal (Mother of Shaquille O'Neal)
Symbolic Firsts—Music	(Partial List) Melissa Etheridge Elton John Boy George	(Partial List) Elton John Eric Clapton Bob Dylan

	George Michael Sinead O'Connor Neil Tenant Andy Bell David Bowie KD Lang Freddie Mercury Ricky Martin Adam Lambert Jaya Kelly (daughter of R. Kelly) Chastity (Chaz) Bono (daughter of Cher) Chely Wright Joan Armatrading	Keith Richards Steven Tyler James Taylor Paul Williams Neil Young Ringo Starr David Bowie Stevie Nicks Johnny Cash Phil Collins Eminem Joe Walsh Lou Reed Keith Urban Ozzie Osborne Grace Slick Judy Collins Natalie Cole Bonnie Raitt George Jones Stevie Ray Vaughan Tim McGraw Nikki Sixx Anthony Kiedis Tom Waits Tim McGraw Chuck Negron
Symbolic First—Television, Film & Entertainment	(Partial List) Rock Hudson Sal Mineo Anthony Perkins Farley Granger Alvin Ailey George Cuckor Ellen Degeneres Guillermo Diaz Jim Parsons Jane Lynch Lily Tomlin Margaret Cho Alanson "Lance" Loud Harvey Fierstein Rosie O'Donnell Jodie Foster Richard Chamberlain George Takei Cynthia Nixon Neil Patrick Harris Wanda Sykes Meredith Baxter Gillian Anderson	(Partial List) Mercedes McCambridge Jason Robards Dick Van Dyke Anthony Hopkins John *Larroquette* Sharon Gless Whoopi Goldberg Robin Williams Martin Sheen William Shatner Ted Danson Samuel L. Jackson Robert Downey Jr. Jamie Lee Curtis Kelly Osborne Carrie Fisher Mackenzie Phillips Rob Lowe Gary Oldman Kristen Johnston Matthew Perry Christopher Kennedy Lawford Russell Brand

	Chastity (Chaz) Bono Agnes Moorehead Sean Hayes Laverne Cox Dustin Lance Black Merce Cunningham John Waters Patricia Neal (Fannie Flag) Judith Anderson Talullah Bankhead Terry Sweeney	Louis Gossett, JR Tom Arnold Danny Trejo
Symbolic Firsts—Noted Authors and Artists	James Baldwin William Burroughs Gertrude Stein Willa Cather Truman Capote John Cheever Allen Ginsberg Jack Keruac Robert Mapplethorpe Annie Leibovitz Susan Sontag Maurice Syndak Gore Vidal Andy Warhol Tennessee Williams Carson McCullers Alice Walker Audre Lorde John Rechy Rita May Brown Edmund White Andrew Holleran Angela Davis Patricia Cornwell Christopher Isherwood Adrienne Rich	Stephen King Susan Cheever David Foster Wallace William Borchert
Symbolic Firsts—Media & Journalism	Anderson Cooper Don Lemon Robin Roberts Rachel Maddow Suze Orman Sam Champion Randy Shilts Andy Cohen Keith Haring Herb Ritts Jerome Robbins Matt Bomer Thomas Roberts	Roger Ebert Linda Ellerbee Elizabeth Vargas Susan Rook William Cope Moyers Heather King Glenn Beck Rush Limbaugh Laurie Dhue

Symbolic Firsts--Religious Leaders	(Partial List) William Johnson Freda Smith Anne Holmes Ellen Barrett Bishop Gene Robinson Rev. Dr. Nancy Wilson Rabbi Chaya Gusfield Rabbi Lori Klein Rabbi Sharon Kleinbaum Rabbi Scott Anderson Rabbi Denis Eger Rev. Peter Gomes Bishop Jeffrey Montoya Bishop Jim Swilley Rev. Dr. Katrina Foster Rev. Troy Perry Right Reverend Doctor Gary Paterson Mary Glasspool Mary Albing Katie Ricks	Father Joseph Martin Pastor John Baker
Symbolic Firsts--Iconic Beauty / Fashion	Jenna Talackova (Transgendered Miss Universe Contestant) RuPaul Andre Charles Bob Paris (champion bodybuilder) Kervyn Aucoin Pat Fields Jean Paul Gaultier Gianni Versace Yves St. Laurent	Tara Connor (Miss USA) Naomi Campbell (model) Kate Moss (model)

Table B: Organizational Infrastructures of LGBT and Recovery Advocacy Movements

Evolving Organizational Infrastructure: LGBT Movement	**Evolving Organizational Infrastructure: Recovery Advocacy Movement**
Society for Human Rights Mattachine Society Daughters of Bilitis Gay Liberation Front Gay Activists Alliance Queer Nation Gay Men's Health Crisis People with AIDS Coalition	National Council on Alcoholism and Drug Dependence (NCADD) Society of American in Recovery (SOAR) Johnson Institute / Alliance Project Faces and Voices of Recovery

Women's Health Action Mobilization (WHAM) Women's Action Coalition (WAC) ACT UP Lesbian Avengers Youth Education Life Line (YELL) Gay, Lesbian, and Straight Education Network (GLESN) Lambda Legal Gay and Lesbian Victory Fund National Gay and Lesbian Task Force Human Rights Campaign	Association of Recovery Community Organizations (ARCO) Young People in Recovery (YPR) Association of Recovery Schools Association of Recovery in Higher Education Transforming Youth Recovery National Alliance of Recovery Residences (NARR)

Table C: Institution Building within the LGBT and Recovery Advocacy Movements

Institutional Arena	**LGBT Movement**	**Recovery Advocacy Movement**
Legal Advocacy	Lambda Legal	Legal Action Center
Health Care	LGBT health initiatives and health centers LGBT mental health and gay-positive therapy centers	Push for new models of addiction treatment, e.g., recovery management & recovery-oriented systems of care Push for integration of addiction treatment and primary care
Social Services	Formation of age-appropriate LGBT social services, serving youth, adult, and senior citizens	Local recovery community organizations Integration of peer recovery support services within addiction treatment and allied agencies
Housing	Preferred LGBT neighborhoods LGBT senior residences	Recovery Residences
Education	LGBT high schools Collegiate Queer Studies programs	Recovery high schools; Collegiate recovery communities
Business/Industry	LGBT Entrepreneurs and LGBT-focused businesses	Recovery entrepreneurs & Recovery-based businesses
Social Networking & Recovery Support	Network of LGBT community centers across country National Association of LGBT Community Centers	Diversification of recovery mutual aid fellowships; Recovery community centers
Religion	LGBT friendly churches; LGBT ministries	Recovery ministries; Faith-based recovery mutual aid fellowships

	Metropolitan Community Churches Unity fellowships	
Sports	Gay Games	Phoenix Multisport Addict2Athlete
Military	Gay veteran groups, e.g., The American Military Partner Association; Service Members, Partners, Allies for Respect and Tolerance for All (SPARTA), American Veterans for Equal Rights,	Recovery support groups for veterans Dryhootch

Table D: Cultural Development with the LGBT and Recovery Advocacy Communities

Cultural Dimension	**LGBT Movement**	**Recovery Advocacy Movement**
Symbols/Colors	Rainbow Flag (red, orange, yellow, green blue, purple) Inverted Pink Triangle Lavender Equality sign Lambda symbol	Purple
Slogans	Gay is Good Silence=Death "We're here. We're queer. Get used to it" Out of the bars, and into the streets!	By Our Silence We Let Others Define Us Recovery is Everywhere Recovery Works (We are the Evidence) Recovery is an Expectation
Biographies/Profiles of Movement Figures	Gay Rights Activists Radically Gay (Harry Hay) Lost Prophet (Bayard Rustin) Gay is Good (Frank Kameny) Frank (Barney Frank) Soldier of Change (Stephen Snyder-Hill) Eleanor Roosevelt (Blanch Weisen-Cook)	Broken (William Cope Moyers) Many Faces One Voice Biographies of recovery mutual aid leaders and earlier advocacy leaders, e.g., Bill Wilson, Marty Mann, Harold Hughes, Nancy Olson
Personal Biographies	Innumerable	Innumerable
Lifestyle Magazines	Innumerable The Advocate, Instinct Magazine, Metrosource, Pink Magazine, Curve, San Francisco Bay Times, biMagazine	Serene Scene, Renew, In Recovery, Recovery Today, Recovery Plus, Journey, Recovery Wire

Cultural visibility via roles in film and television and	Film: (Innumerable) Philadelphia The Birdcage Brokeback Mountain Angels in America The Imitation Game Capote Wonder Boys J. Edgar As Good as it Gets Milk Kiss of the Spider Woman Girl with the Dragon Totoo The Crying Game Midnight in the Garden of Good and Evil Silkwood LGBT Roles in Television and Actors who played them: Partial List: Will and Grace (Sean Hayes, Eric McCormack) Friends (Susan Bunch) Glee (Naya Rivera, Alex Newell, Darren Criss, Demi Lovato, Grant Gustin) Grey's Anatomy (Jessica Capshaw) Six Feet Under (Michael Hall) Empire (Jussie Smollett) Plays: The Lonely Heart Fortune in Men's Eyes Safe Home Cruising Boys in the Band Angels in America	Film: Clean and Sober 28 days My Name is Bill W. Bill W. (Documentary) Drunks When a Man Loves a Woman Recovery Roles in Television and Actors who played them: Hill Street Blues (Daniel J. Travanti); NYPD (Dennis Franz); Cheers (Ted Danson); Rescue Me (Dennis Leary); Entourage (Adrian Grenier); Nurse Jackie (Edie Falco); The West Wing (John Spenser); Mom (Allison Janney); Terriers (Donal Logue); Grace Under Fire (Brett Butler) Plays: Bill W. and Dr. Bob
LGBT or recovery experience expressed through fictional characters in a popular novel	Character/Author (Innumerable—some of the recurring characters listed below) Milo Sturgis (Jonathon Kellerman) Bernie Rhodenbarr (Lawrence Block)	Character/Author Dave Robicheaux (James Lee Burke novels) J.P. "Beau" Beaumont (J.A. Jance mysteries) Matt Scudder (Lawrence Block mysteries)

	Lucy Farinelli (Patricia Cornwell) Kate Delafield (Katherine Forrest) Jane Lawless (Ellen Hart) Kate Martinelli (Laurie King) Cherry Aimless (Mabel Maney) Dr. Blue McCarron (Abigal Padgett) Pharoah Love (George Baxt) Nick Hoffman (Lev Raphael) Donald Strachney (Ricahrd Stevenson) Lauren Laurano (Sandra Scoppettone)	Mark Schorr (Brian Hanson mysteries) Bruce Kohler (Elizabeth Zelvin mysteries) Maggie Elliot (Elizabeth Atwood Taylor's The Northwest Murders) Cody Hoyt (C.J. Box mysteries) Samantha Adams (Sara Shankman Father John (Margaret Coel) Ruby Murphy (Maggie Estep) John Jordan (Michael Lister) Dixon Sinclair (Caroline Haines)
Literary Awards	Ferro-Grumley Award, Lamda Literary Award, Dayne Stonewall Book Award, Ogilvie Prize. Gaylactic Spectrum Awards	McGovern Family Foundation Award (no longer being awarded)
Musical Anthems	Y.M.C.A. Dancing Queen I Will Survive Beautiful Born This Way	Stronger as we Rise
Ritualized Celebration	Gay Pride Month/Parades (June) National Coming Out Day	Recovery Month/Walks (September) America Honors Recovery
Professional Guilds	(Innumerable—partial list) National Gay and Lesbian Chamber of Commerce	International Doctors in Alcoholics Anonymous (IDDA) Professional Assistance Programs

	National Organization of Gay and Lesbian Scientists and Technical Professionals Gay and Lesbian Medical Association Lesbian, Gay, Bisexual and Transgender People in Medicine (LGBTQPM) Association of Gay and Lesbian Psychiatrists Society of Lesbian and Gay Anthropologists Law Enforcement Gays and Lesbians International National Lesbian and Gay Law Association International Association of Lesbian & Gay Judges National Association of Lesbian and Gay Addiction Professionals (NALGAP) The Sociologists' Lesbian, Gay, Bisexual and Transgendered Caucus American Historical Association. Committee on Lesbian and Gay History (CLGH)	

Table E: Policy and Regulatory Changes Affected by the LGBT and Recovery Advocacy Movements

Area of Change	**LGBT Movement Milestones**	**Recovery Advocacy Movement Milestones**
Psychiatric Diagnosis & Treatment	*Removal of homosexuality as a psychiatric diagnosis in DSM II *Professional and legal bans on aversion/conversion therapy	*Removal of "abuse" language in diagnosis of substance use disorders *Consensus definitions on definition of recovery

		*Push for models of recovery management & recovery-oriented systems of care * Push for recovery research agenda * Federal/state/private funding of peer-based recovery support services * Comprehensive Addiction & Recovery Act of 2015 in House and Senate
Status Laws	Repeal of laws that criminalized homosexual acts (Supreme Court, Romer v. Evans, 1996); state-by-state repeal of sodomy laws, reinforced by 2003 Supreme Court decision Introduction of The Equality Act in U.S. House and Senate in 2015	Repeal of laws making status of addiction illegal (Robinson v. California; Powell v. Texas) 2009 revision of NY Rockefeller Drug Laws Changes in sentencing for crack cocaine possession Liberalization of laws on marijuana possession
Marriage Laws	Same-sex marriage laws passed in 36 states & District of Columbia Followed by June 26, 2015 Supreme Court declaration that bans on same sex marriages were unconstitutional (Obergefell, et al V. Hodges, Director, Ohio Department of Health, et al)	
Discrimination in Housing, Employment, Education	Bans on discrimination based on sexual orientation or gender identity ▪ Repeal of anti-gay laws and ordinances (Dade County, Oregon, Colorado, CA Prop 8) ▪ LGBT rights ordinances: municipal, county, and state	Inclusion of addiction within American with Disabilities Act State and municipalities Ban the Box initiatives
Discrimination in Military	From ban on participation before 2011 to "Don't ask, don't tell" (DADT) to repeal of DADT in 2011. (Transgender people still	

	excluded from military service.)	

Table F: Growth of Historical Consciousness within the LGBT and Recovery Advocacy Movements

LGBT Movement History	Film Treatments of the LGBT Movement	Recovery Advocacy Movement History	Film Treatments of the Recovery Advocacy Movement
(Partial List) Making Gay History Forging Gay Identities Stonewall (Bausum) Stonewall (Carter) The Gay Revolution Law & the Gay Rights Story Gay Power Out for Good Gay America The Gay Rights Movements Queers in Court Rainbow Rights Created Equal Gay Rights & Moral Panic The Music that Inspired the Gay Rights Movement Queer Cultures	(Partial List) We Were Here Silence=Death And the Band Played On Stonewall Uprising The Times of Harvey Milk How to Survive a Plague Milk United in Anger Before Stonewall Ask Not Out Late Outrage The Normal Heart In Love and Anger (bio of Larry Kramer)	(Complete List) Slaying the Dragon Circles of Recovery With a Lot of Help from our Friends Let's Go Make Some History Language of the Heart Many Faces One Voice	(Complete List) The Anonymous People



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. Daneshmand, R., Funk, R. & Dezhakam, H. (2016). A pilot study of smoking cessation within an Iranian recovery community. *Alcoholism Treatment Quarterly*, 34(1), 15-29. Posted at **www.williamwhitepapers.com**

A Pilot Study of Smoking Cessation within an Iranian Addiction Recovery Community

William L. White, M.A.
Chestnut Health Systems, Bloomington, Illinois, USA

Reza Daneshmand, M.D.
Private Psychiatric Practice, Tehran, Iran

Rod Funk, B.S.
Chestnut Health Systems, Bloomington, Illinois, USA

Hossein Dezhakam, B.S.
Congress 60, Tehran, Iran

ABSTRACT

Tobacco dependence is ubiquitous among people seeking treatment for other substance use disorders, compromises recovery outcomes, and elevates long-term morbidity and mortality of people recovering from other addictions. The present study: 1) identifies the organizational and personal motivators for smoking cessation within a recovery community (Congress 60) in the Islamic Republic of Iran, 2) describes a novel method of smoking cessation that combines prolonged nicotine replacement therapy (NRT) with a broad spectrum of psychosocial supports to achieve sustained smoking cessation and improved health and quality of life (HQOL), and 3) presents preliminary follow-up data on the first 100 individuals who participated in this pilot effort. The high retention rate, low reported nicotine cravings during and following NRT, high one-year post-NRT abstinence rates, and reported improvements in HQOL of study participants warrant further evaluation and potential replication of the smoking cessation methods used within Congress 60.

Keywords: tobacco dependence, smoking cessation, nicotine replacement therapy, peer recovery support

Introduction

Smoking (nicotine dependence) remains the leading cause of preventable disease and death worldwide in spite of international advances in tobacco control policies, public education, and research-informed methods of smoking cessation (Giovino et al., 2012). One-third to one-half of lifelong smokers will die of smoking-related illnesses (USDHHS, 2004). Smoking-related disease and death exact a particularly heavy toll on people with co-occurring drug dependencies.

People seeking treatment for addiction other than nicotine dependence report exceptionally high (80%+) rates of smoking (nearly four times the rate of reported in the general population; Ong, Zhou, & Sung, 2011), more severe patterns of nicotine dependence (Bien & Burge, 1990; Burling, 2003), and fewer smoking cessation attempts than smokers without co-occurring drug dependencies (Hays et al., 1999). As a result, people treated for alcohol or drug dependence are more likely to subsequently die from smoking-related diseases than from other drug-related causes (Hser, McCarthy, & Anglin, 1994; Hurt et al., 1996). Research to date confirms that concurrent addiction to nicotine and other drugs amplifies the health risks of each addiction and the total burden of associated diseases (Kalman, Kim, DiGirolam, Smelson, & Ziedonis, 2010).

Such findings have sparked growing interest in integrating smoking cessation resources within professionally-directed addiction treatment and in peer-led recovery mutual aid fellowships and other recovery community organizations (White, 2008, 2014). Such efforts have further accelerated in the wake of three critical research findings: 1) smoking cessation attempts in early recovery from other drug addictions do not increase cravings for those other drugs (Cooney, Cooney, Pilkey, Kranzler, & Onken, 2003), 2) continued smoking during and following treatment for alcohol and drug dependence is a risk factor for resumption of alcohol and other drug use (Sobell, Sobell, & Kozlowksi, 1995), and 3) smoking cessation reduces the risk of relapse and increases the odds of sustained recovery from alcohol and other drug addictions (Bobo, McIlvain, Lando, Walker, & Leed-Kelley, 1998; Hughes, Keely, & Naud, 2004; Kalmon et al., 2001, 2010; Kohn, Tsoh, & Weisner, 2003; Lemon, Friedmann, & Stein, 2003; McCarthy, Collins, & Hser, 2002; Prochaska, Delucchi, & Hall, 2004; Satre, Kohn, & Weisner, 2007; Stuyt, 1997). Also influential have been findings that smoking cessation increases life expectancy; reduces risk of heart disease, heart attacks, strokes, and cancer; and leads to a more rapid process of brain recovery from other addictions (American Legacy Foundation, 2010; Kalman, et al., 2010).

Most smokers regret starting to smoke (90%), want to quit and have made a prior attempt to quit (70%), or are currently trying or planning to quit (40%) (Hughes, Marcy, & Naud, 2008; Bonnie, Stratton, & Wallace, 2007), but relapse rates are high following smoking cessation attempts (American Legacy Foundation, 2014). Successfully quitting smoking often involves cycles of abstinence, lapse, relapse, remorse, remotivation, and renewed abstinence attempts (Bonnie, et al., 2007). Those who attempt to quit smoking report an average of 8-11 quit attempts before succeeding, with most relapsing within the first eight days following their last cigarette (Hughes et al., 2004; USDHHS, 2001).

The professional treatment of nicotine dependence currently integrates medical interventions such as nicotine replacement therapy (NRT); targeted medications such as

varenicline, bupropion, or cytisine; and various forms of behavioral and social support for smoking cessation. While these methods are being integrated into some addiction treatment programs, the field has yet to forge a systematic response to the issue of nicotine dependence and its consequences. Also of concern is the lack of response to this issue by addiction recovery mutual aid fellowships.

The present study explores the introduction of a smoking cessation track within Congress 60--a prominent recovery community within the Islamic Republic of Iran. The study: 1) identifies the organizational and personal motivators for smoking cessation within Congress 60, 2) describes a novel method of smoking cessation that combines prolonged NRT and a broad spectrum of psychosocial supports, and 3) presents preliminary follow-up data on smoking status and health and quality of life (HQOL) of the first 100 individuals who participated in this pilot effort.

Methodology

Setting Congress 60 is a recovery community in the Islamic Republic of Iran founded by Mr. Hossein Dezhakam in 1998 to address problems of opioid and other drug addictions (Dezhakam, 2011b). Congress 60 has 19 branches in Tehran and 22 branches in other Iranian cities. It provides more than 6,800 educational workshops each year with an average of 150 participants per workshop. Congress 60 currently has more than 25,000 members in its branches (White, in press). The recovery program of Congress 60 consists of the DST method (an 11-month process of drug tapering using opium tincture, see White, in press) combined with intensive psychosocial support provided within a philosophy of recovery called the 14 Valleys (Dezhakam, 2011b) that is analogous to the Twelve Steps of Alcoholics Anonymous. Members are provided Guides (peer mentors/coaches) and are encouraged to become engaged in a broad spectrum of athletic, religious, artistic and cultural activities within Congress 60, and the larger community (Dezhakam, 2011a).

Historically, there was no systematic approach to address the high smoking rate of Congress 60 members (90%+ compared to the 11.3% daily smoking rate in Iran; Meysamie et al., 2010, 2012) other than informal encouragement to switch to lower tar or nicotine brands and reduce the number of cigarettes smoked per day. This changed in 2012 when Mr. Dezhakam experienced a near-death health crisis (heart attack requiring resuscitation). This event triggered a re-evaluation of the effect of nicotine addiction on HQOL in long-term recovery from other addictions. As a result, a voluntary program of smoking cessation was initiated within Congress 60. To date, more than 300 members of Congress have completed nicotine replacement (as of February 20, 2015).

Subjects The first 100 members who voluntarily enrolled in the smoking cessation program within the 19 Congress 60's Tehran branches, following appropriate informed consent procedures, were invited to participate in a pilot study evaluating the effectiveness of the methods being used to achieve smoking cessation. The subjects were primarily male (89%), middle-aged (40.1% mean; SD 10.9%), and married (75%) with children (63%). Fifty-one percent of subjects had completed high school and an additional 25% had attended or completed college or had an advanced degree. Seventy-seven percent of subjects were employed. Ninety-one percent of subjects had entered Congress 60 seeking recovery from opioid addiction (opium, opium sap, charred opium, heroin, methadone or other narcotics). Ninety-two percent had used the DST method of tapering with opium tincture that was recommended within Congress 60. All

of the subjects had been involved in Congress 60 for six months or more before participating in the smoking cessation pilot. Fifty-seven percent of subjects began smoking before the age of 18, and subjects averaged smoking 24.2 cigarettes per day prior to entering the study (compared to the average of 13.7 cigarettes per day for all smokers in Iran, Meysami, Ghaletaki, Zhand, & Abbasi, 2012). Fifty-three percent reported no past quit attempts, while others had attempted to quite using unaided withdrawal (38%), using bupropion without NRT (1%), or NRT without adjunctive medication (8%). The average longest period of prior smoking abstinence since establishment of nicotine addiction among the 100 subjects was 10 days. Of the 100 subjects, 12% had been diagnosed with prior cardiovascular problems, 11% with respiratory disease, 8% with a psychiatric illness, and 22% with other medical conditions.

Intervention The pilot study involved evaluation of the self-perceived effects of a voluntary program of smoking cessation by selected members of Congress 60. The smoking cessation intervention involved three steps: 1) calculating each individual's daily baseline nicotine dosage achieved through smoking and then switching nicotine intake from smoking to an equivalent dosage of nicotine gum for a period of three months, 2) then progressively decreasing the daily dosage of nicotine gum over a subsequent period of at least 10 months, and then continuing the psychosocial supports extended through steps 1 and 2 for an indefinite period following nicotine abstinence. During the stabilization and tapering period, subjects were provided a trained "guide" who had achieved at least three months of abstinence following smoking cessation. All subjects were encouraged and expected to participate in weekly special "legion" meetings (group support meetings for members of Congress 60 committed to smoking cessation).

The approach to nicotine replacement and subsequent abstinence is modeled on the "DST method" used in the treatment of other drug addictions within Congress 60, with the "D" meaning the decrease coefficient of 0.8 (and which is the first initial of Dezhakam who is the designer of the DST method) at each increment of dose reduction, "S" meaning that each step of dosage reduction is maintained for at least 21 days, and "T" meaning the minimum time between initiation of nicotine replacement and complete nicotine abstinence is at least 10 months. For example, one who is using 20 milligrams of nicotine will be first tapered (20 X 0.8=16 milligrams) and then 21 days later tapered again at the 0.8 level. Of the multiple methods of nicotine replacement therapy (gum, transdermal patch, oral nicotine spray, nasal spray, inhaler and sublingual tablets/lozenges), nicotine gum was chosen as a method of NRT because of its over-the-counter availability, affordability, ease of dose regulation, ability to accommodate individual differences in nicotine metabolism, ability to rapidly address situation-induced cravings, its reported minimum of adverse effects, and past studies affirming the utility of NRT and the use of nicotine gum with persons undergoing addiction treatment (Ahmadi, Ashkani, Ahamadi, & Ahmadi, 2003; Carpenter et al., 2013; Cooney et al., 2009; Heydari, Masjedi, et al., 2014; Heydari, Talischi, et al., 2014; Raupach, Brown, Herbec, Brose, & West, 2013).

In the DST method of smoking cessation used in the pilot, there was no change in initial oral nicotine dose during the first three months of initial adjustment to oral nicotine ingestion. Tapering of oral nicotine started at the 3-month mark. For each subject, the baseline oral nicotine dose was calculated based on the number of cigarettes smoked per a day. The desired dosage was achieved by dividing each piece of 2 milligrams nicotine gum into fourths (with each part containing 0.5 milligrams) and consuming the total prescribed daily amount in increments at times chosen by each subject. With the DST method, the focus was not on immediate cessation of nicotine dependence, but on needed restoration and repair of metabolic and emotional

functioning—healing that through experience was thought to require an average of 10-11 months. Subjects who wanted to move at a faster pace toward nicotine abstinence were discouraged from premature cessation as experience with the DST method with other addictions had linked such premature efforts to an increase risk of relapse (White, 2012, in press).

Psychosocial support during nicotine replacement therapy consisted of four elements. The first element was assignment of a guide who met with each subject weekly to provide information on the DST method, establish the proper nicotine tapering schedule, check on weekly progress, discuss any problems that are arising and offer suggestions based on personal and collective experience. The second element was participation in the weekly "legion" mutual support meetings for those members of Congress 60 who have committed themselves to smoking cessation. These legions, facilitated by the trained guides, operate within each branch of Congress 60, with the number of members in each legion ranging from two to 20. Legion meetings were available to and used by all of the study participants. These weekly meetings consisted of mutual sharing and support, review of problems being encountered, and discussions of potential solutions. The legion meetings helped members cope with stressors without reverting to smoking or other drug use. The third dimension was an emphasis on the involvement of legion members in the larger athletic, artistic, cultural, and community service activities of Congress 60. These activities provided alternatives to smoking as well as social relationships in which the value of smoking cessation was extolled. The fourth element was a re-orientation of one's understanding of addiction recovery as encompassing smoking cessation. This latter dimension of spirituality or worldview involved use of the principles within the 14 Valleys to cope with any physical or psychological discomforts of smoking cessation.

Research Questions The pilot study of smoking cessation within Congress 60 tested four research questions. One year following participation in tapering and group support, what percentage of study participants will report: 1) successful completion of the smoking cessation protocol, 2) having experienced minimal nicotine craving during and following the period of NRT, 3) sustained smoking cessation without relapse, and 4) significant improvements in HQOL.

Instrumentation and Measurement 100 subjects were interviewed at intake and at follow-up using a standardized intake form and follow-up interview protocol. The interviews were all conducted by Dr. Reza Daneshmand, a psychiatrist practicing in Tehran, who was recruited to assist with the research. Intake data collection spanned nicotine addiction history, history of other addictions, history of physical and mental illnesses, and motivations for wanting to quit smoking. Post-treatment data collection reporting status during and following the smoking cessation procedures spanned ratings of craving intensity, nicotine abstinence or use, HQOL measures, and degree of participation in support group activities. Data collected by Dr. Daneshmand were coded and electronically transmitted to research staff at Chestnut Health Systems in Bloomington, Illinois (USA) for analysis.

Ethical Oversight The study design and human subject protections were approved by the Chesnut Health Systems Institutional Review Board.

Findings

Baseline and follow-up data were available for 93 of the 100 study participants. The average time between completion of nicotine replacement and follow-up was 9.7 months, with a range from 1 to 19 months.

Motivation for Smoking Cessation Study subjects ranked their motivations to stop smoking within the following four primary categories: concerns about physical/psychological health (82%), social and job issues (57%), family issues (38%), and economic issues (11%).

Retention There was an exceptionally high retention rate within the study, with 93 of 100 completing the process of smoking cessation and participating in follow-up interviews.

Ratings on Level of Nicotine Craving The average rating of nicotine craving during the months of NRT was 2.4 out of 10 with 0 representing lowest and 10 representing highest level of experienced craving. The reported range was from 1 to 8. The average rating of craving for smoking after completion of NRT was 1.2 out of 10 with a range of 0 to 3.

Ratings of DST Method of Nicotine Replacement Participants rated the DST nicotine replacement method on a scale from 0 (not effective) to 10 (extremely effective) with an average rating of 9.6 out of 10.

Degree of Participation in and Helpfulness of Legion Meetings The degree of self-reported sharing within the legion meetings spanned no sharing in meetings (5%), seldom sharing in meetings (26%), and frequent sharing in meetings (69%). The average rating of perceived helpfulness of legion participation was 8.7 out of 10 with 58% rating helpfulness at 10 out of 10.

Intervention and Post-intervention Rates of Smoking Abstinence Eighty-five percent of participants reported no smoking during the months of NRT using the DST method, 8% reported smoking 1 cigarette, and 8% reported smoking 2-7 cigarettes. After completion of DST nicotine replacement, only 1 participant reported smoking (1 cigarette); the rest reported no smoking (N= 92).

Health and Quality of Life (HQOL) Ratings following Smoking Cessation Ninety-two of 100 study subjects reported HQOL ratings at the point of follow-up (See Table 1).

Table 1: HQOL Rating at Smoking Cessation Follow-up (n=92)

	No Change	Somehow Better	Better	Improving	Worse
Evaluation of physical health after smoking cessation	1.1%	2.2%	30.4%	65.2%	1.1%
Evaluation of sports and exercise after smoking cessation	1.1%	4.3%	35.9%	57.6%	1.1%

Evaluation of appearance after smoking cessation	3.3%	9.8%	48.9%	37.0%	1.1%
Evaluation of mental abilities after smoking cessation	15.6%	27.8%	40.0%	16.7%	0.0%
Evaluation of psychological status after smoking cessation	6.5%	20.7%	41.3%	31.5%	0.0%
Evaluation of family relationship after smoking cessation	3.3%	12.0%	37.0%	47.8%	0.0%
Evaluation of job abilities after smoking cessation	17.4%	17.4%	45.7%	19.6%	0.0%

Differences in Outcomes by Source of Primary Motivation for Smoking Cessation Ratings for craving for smoking during and after nicotine replacement, the degree of sharing and effectiveness ratings of legion meetings, and post treatment abstinence rates were examined to see if they differed by the sources of motivation for smoking cessation (e.g., family issues, psychological or physiological issues, and job or social issues). T-test analysis did not reveal any significant differences ($p < .05$) on any of these outcomes by whether or not the subject endorsed the particular motivator as a priority. We did see one trend on craving for smoking during nicotine gum taking in which those who said social and job issues were a priority reported higher craving ($M = 2.7$) than those who did not ($M = 2.1$; $p = .081$). We also examined the post-treatment status of such factors as physical health, sports and exercise, appearance, mental abilities, psychological status, family relationships and job abilities to see if they differed by the source of motivation for smoking cessation. Only one chi-square test was significant. Fifty-six percent of those reporting family issues as a priority to quit smoking rated their appearance after smoking cessation as improving compared to only 26% of those who did not endorse family issues as a priority, $\chi^2(4) = 12.53$, $p < .01$.

Discussion

A study was conducted on a unique approach to smoking cessation piloted within Congress 60, a recovery community in the Islamic Republic of Iran. In-treatment and post-treatment outcomes were reported on 100 subjects enrolled in a smoking cessation pilot that combined a prolonged process of NRT with extensive psychosocial support.

The DST method of transitioned nicotine replacement to nicotine abstinence produced a 93% retention/completion rate among the 100 subjects. Several factors likely contributed to this exceptionally high retention rate. All subjects were already socially bonded members of Congress 60. Participants volunteered from a pool of thousands of Congress 60 members and were likely the most motivated to stop smoking. The emphasis on the value of smoking cessation

and the importance of the study as communicated by Mr. Hossein Dezhakam, the founder of Congress 60, likely served as an additional influence on the high retention rates among study participants. This retention rate does suggest that a recovery community in which tobacco dependence has become entrenched can implement changes that increase smoking cessation efforts.

Study participants reported minimal nicotine craving during and following use of the DST method of NRT. Craving ratings of 2.4 (in-treatment) and 1.2 (post-treatment) of a 1-10 craving intensity scale suggest that the DST method of NRT was able to suppress the intense cravings often association within smoking relapse. The low reported cravings using the DST method are important in light of past research suggesting the strong link between craving intensity and smoking cessation outcomes (Wray, Gass, & Tiffany, 2013).

The authors did not anticipate the exceptionally high in-treatment (85%) and post-treatment (99%) abstinence rates. These rates are far higher than the one-year abstinence rates (less than 30%) reported in other smoking cessation studies (Cahill, Stevens, Perera, & Lancaster, 2013; Carpenter et al., 2013), including other studies in Iran (Heydari, Marashian, Ebn Ahmady, Masjedi, & Lando, 2012; Shahrokhi,et al., 2008). In fact, the rates were so high that little factor analysis was possible comparing those for whom this method was and was not effective.

This effectiveness in retaining smoking cessation participation, suppressing cravings and promoting in-treatment and post-treatment smoking abstinence is likely association with four factors within the methods being piloted by Congress 60. First, the DST method combines NRT with behavioral techniques and social support for smoking cessation—a combination principle already established to have value in the smoking cessation research literature (Hartmann-Boyce, Stead, Cahill, & Lancaster, 2013; Stead & Lancaster, 2012a,b; Stead et al., 2012).

Second, the DST method of NRT provides a longer period of dose stabilization prior to tapering, and a much longer period of tapering than is usually found within the smoking cessation literature (Kotz, Brown, & West, 2014). Most studies of NRT sustain NRT for weeks, and only a few such studies have protocol that continue NRT for more than six months (Carpenter et al., 2013). The present study findings are consistent with earlier findings that cessation rates improve with a longer period of NRT (Siahpush et al., 2015), but the present study extends the duration of NRT far longer than in most previous studies and provides smaller increments of nicotine dose reduction.

Third, Congress 60 provides a highly intense and prolonged level of one-on-one guidance and mutual support that also capitalized on the therapeutic effects of helping as proposed by Riessman (1965) and confirmed in multiple studies of smoking cessation (Ford, Clifford, Gussy, & Gartner, 2013), and broader studies of addiction recovery (Pagano, Post, & Johnson, 2011; White, 2009). Earlier studies report increasing the odds of successful smoking cessation from 10-25% by adding behavioral/social support to NRT over short periods (e.g., weeks) of time (Stead & Lancaster, 2012a,b). The present study exponentially extended the duration of such support. The peer support component of the present study was designed to provide opportunities for mutual identification, visible role models for successful smoking cessation, increased self-efficacy, and opportunities for exposure to and mastery of new knowledge and coping skills. Every effort was made to channel the social contagion that once supported smoking among the members of Congress 60 to support smoking cessation.

Fourth, smoking cessation within Congress 60 occurs within the context of alternative activities and the reconstruction of one's worldview (framing smoking cessation within larger rubric of addiction recovery and spiritual renewal). This factor is analogous to the well-documented use of replacement activities, identity reconstruction, and the linking of addiction recovery to a larger meaning and purpose in life across religious, spiritual and secular frameworks of addiction recovery (Kurtz & White, 2015; Laudet, Morgen, & White, 2006; White, 1996). Future studies should attempt to disaggregate and measure the influence of these respective factors. Collectively, these factors confirm the principle that smoking cessation rates improve with the increased intensity and duration of physical, psychological, social, and spiritual support for smoking cessation (Stead & Lancaster, 2012a,b; Zwar et al., 2015).

> Subjects completing smoking cessation using the DST method of NRT also reported significant improvements in health and quality of life. When ratings of "better" and "now improving" were combined, substantial improvements in HQOL were reported in such areas as physical health (95.6%), participation in sports and exercise (93.5%), appearance (85.9%), family relationships (84.8%), psychological health (72.8%), job performance (65.3%), and mental abilities (56.7%). Such reports are consistent with other studies of the effects of smoking cessation on lowering morbidity and mortality risks and enhancing overall HQOL (Goldenberg, Danovitch, & IsHak, 2014).

Limitations

The reported outcomes in this pilot study should be interpreted with great caution due to the limitations that often accompany small pilots that precede larger, more methodologically rigorous studies. Congress 60 is a unique recovery community in Iran whose members may differ significantly from members of other secular, spiritual and religious recovery mutual aid societies in Iran and in other countries as well as from patients seeking professionally-directed addiction treatment. The first volunteers to test the DST method of smoking cessation were also unique in that they were likely among the most motivated to stop smoking and most interested in enhancing the reputation of Congress 60 and its leadership. Future studies will be required to see if the reported outcomes can be sustained in future generations of Congress 60 members availing themselves of these methods. Resources were not available in the pilot study to compare the results of participants with a matched control group of individuals using other methods of smoking cessation or other Congress 60 members who maintained their recovery from other drug dependencies but continued to smoke tobacco. The study also relied on self-report of smoking behavior without biochemical validation of smoking status via measurement of exhaled CO and self-reported changes in HQOL without independent verification of these changes. Future studies in Congress 60 and in other recovery community and professional treatment settings and with greater methodological rigor will help determine the degree to which the utility of the methods used within Congress 60 will be effective in other cultural and professional contexts.

Conclusions

In spite of the noted limitations, the high retention rate, low reported nicotine cravings during and following NRT, the high one-year post-NRT abstinence rates, and the improvements in HQOL reported in this study all suggest the value in further testing of the smoking cessation methods used within Congress 60. Combining prolonged NRT, peer-based recovery support groups, inclusion of nicotine abstinence within the conceptual rubric of "addiction recovery," and

framing smoking cessation within the larger recovery-driven reconstruction of identify, relationships, and daily lifestyle may provide an effective framework of smoking cessation for individuals who are seeking or achieving recovery from multiple drug dependencies.

References

Ahmadi, J., Ashkani, H., Ahmadi, M., & Ahmadi, N. (2003). Twenty-four week maintenance treatment of cigarette smoking with nicotine gum, clonidine and naltrexone. *Journal of Substance Abuse Treatment*, *24*(3), 251-255. doi:10.1016/S0740-5472(03)00027-8

American Legacy Foundation. (2014). *Smoking cessation fact sheet.* Washington D.C.: American Legacy Foundation. Retrieved February 23, 2015 from http://www.legacyforhealth.org/content/download/6170/77493/version/1/file/Legacy+Smoking+Cessation+Fact+Sheet.pdf

Bien, T. H., & Burge, R. (1990). Smoking and drinking: A review of the literature. *International Journal of the Addictions*, *25*, 1429-1454. doi: 10.3109/10826089009056229

Bobo, J. K., Mcllvain, H. E., Lando, H. A., Walker, R. D., & Leed-Kelley, A. (1998). Effect of smoking cessation counseling on recovery from alcoholism: Findings from a randomized community intervention trial. *Addiction, 93*, 877-887. doi:10.1046/j.1360-0443.1998.9368779.x

Bonnie, R. J., Stratton, K., & Wallace, R. B. (Eds., 2007). *Ending the tobacco problem: A blueprint for the nation*. Washington, D.C.: Institute of Medicine.

Burling, T. A. (2003). A comparison of self-report measures of nicotine dependence among male drug/alcohol dependent cigarette smokers. *Nicotine and Tobacco Research*, *5*, 625-633. doi:10.1080/1462220031000158708

Cahill, K., Stevens, S., Perera, R., & Lancaster, T. (2013). Pharmacological interventions for smoking cessation: An overview and network meta-analysis. *Cochrane Database of Systematic Reviews*, *5*, CD009329. doi:10.1002/14651858.CD009329.pub2

Carpenter, M. J., Jardin, B. F., Burris, J. L., Mathew, A. R., Schnoll, R. A., Rigotti, N. A., & Cummings, K. M. (2013). Clinical strategies to enhance the efficacy of nicotine replacement therapy for smoking cessation: a review of the literature. *Drugs*, *73*(5), 407-426. doi:10.1007/s40265-013-0038-y

Cooney, J. L., Cooney, N. L., Pilkey, D. T., Krnazler, H. R., & Onken, C.A. (2003). Effects of nicotine deprivation on urges to drink and smoke in alcoholic smokers. *Addiction*, *98*, 913-921. doi:10.1046/j.1360-0443.2003.00337.x

Cooney, N. L., Cooney, J. L., Perry, B. L., Carbone, M., Coeh, E. H., Steinberge, H. R., Pilkey, D. T., Sevarino, K., Oncken, C. A., & Litt, M. D. (2009). Smoking cessation during alcohol treatment: A randomized trial of combination nicotine patch and gum. *Addiction*, *104*, 1588-1596. doi:10.1111/j.1360-0443.2009.02624.x

Dezhakam, H. (2011a). *Crossing the zone 60 degrees below zero*. Tehran, Islamic Republic of Iran: Congress 60.

Dezhakam, H. (2011b). *Love: Fourteen valleys for recovery*. Tehran, Islamic Republic of Iran: Congress 60.

Ford, P., Clifford, A., Gussy, K., & Gartner, C. (2013). A systematic review of peer-support programs for smoking cessation in disadvantaged groups. *International Journal of Environmental Research and Public Health*, *10*(11), 5507-5522. doi:10.3390/ijerph10115507

Giovino, G. A., Mirza, S. A., Samet, J. M., Gupta, P. C., Jarvis, M. J., Bhala, N., Peto, R., Zatonski, W., Hsia, J., Morton, J., Palipudi, K. M., & Asma, S. (2012). Tobacco use in 3 billion individuals from 16 countries: an analysis of nationally representative cross-sectional household surveys. *Lancet*, *380*(9842), 668-679. doi:10.1016/S0140-6736(12)61085-X

Goldenberg, M., Danovitch, I., & IsHak, W. W. (2014). Quality of life and smoking. *American Journal of Addiction, 23*(6), 540-562. doi:10.1111/j.1521-0391.2014.12148.x

Hartmann-Boyce, J., Stead, L. F., Cahill, K., & Lancaster, T. (2013). Efficacy of interventions to combat tobacco addiction: Cochrane update of 2012 reviews. *Addiction*, *108*(10), 1711-1721. doi:10.1111/add.12291

Hays, J. T., Schroeder, D. R., Offord, K. P., Croghan, I. T., Patten, C. A., Hurt, R. D.,…Fiore, M. C. (1999). Response to nicotine dependence treatment in smokers with current and past alcohol problems. *Annals of Behavioral Medicine*, *21*(3), 244-250. doi:10.1007/BF02884841

Heydari, G., Marashian, M., Ebn Ahmady, A., Masjedi, M., & Lando, H.A. (2012). Which form of nicotine replacement therapy is more effective for quitting smoking? A study in Tehran, Islamic Republic of Iran. *Eastern Mediterranean Health Journal*, *18*(10), 1005-1010.

Heydari, G., Masjedi, M., Ahmady, A. E., Leischow, S. J., Lando, H. A., Shadmehr, M. B., & Fadaizadeh, L. (2014). A comparative study on tobacco cessation methods: a quantitative systematic review. *International Journal of Preventive Medicine*, *5*(6), 673-678.

Heydari, G., Talischi, F., Batmanghelidj, E., Pajooh, M. R., Boroomand, A., Zamani, M., Salehi, A., & Maddah, S. (2014). Dual addictions, parallel treatments: nicotine replacement therapy for patients receiving methadone treatment in the Islamic Republic of Iran. *Eastern Mediterranean Health Journal*, 19(Suppl 3), S25-31.

Hser, Y. I., McCarthy, W. J., & Anglin, M. D. (1994). Tobacco use as a distal predictor of mortality among long-term narcotic addicts. *Prevention Medicine*, *23*, 61-69. doi:10.1006/pmed.1994.1009

Hughes, J. R., Keely, J., & Naud, S. (2004). Shape of the relapse curve and long-term abstinence among untreated smokers. *Addiction*, *99*(1), 29-38. doi:10.1111/j.1360-0443.2004.00540.x

Hughes, J. R., Marcy, T. W., & Naud, S. (2008). Interest in treatments to stop smoking. *Journal of Substance Abuse Treatment*, *36*, 18-24. doi:10.1016/j.jsat.2008.04.002

Hurt, R. D., Offord, K. P., Vroghanm I. T., Gomez-Dahl, L., Kottke, T. E., Morse, R. M., & Melton, J. (1996). Mortality following inpatient addictions treatment. *Journal of the American Medical Association*, *274*(14), 1097-1103. doi:10.1001/jama.1996.03530380039029

Kalman, D., Haves, K., Colby, S. M., Eaton, C. A., Rohsenow, D. J., & Monti, P. M. (2001). Concurrent versus delayed smoking cessation treatment for persons in early alcohol recovery: A pilot study. *Journal of Substance Abuse Treatment*, *20*, 233-238. doi:10.1016/S0740-5472(00)00174-4

Kalman, D., Kim, S., DiGirolam, G., Smelson, D., & Ziedonis, Z. (2010). Addressing tobacco use disorder in smokers in early remission from alcohol dependence. *Clinical Psychology Review*, *30*(1), 12-24. doi:10.1016/j.cpr.2009.08.009

Kohn, C. S., Tsoh, J. Y., & Weisner, C. M. (2003). Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. *Drug and Alcohol Dependence*, *69*, 61-71. doi:10.1016/S0376-8716(02)00256-9

Kotz, D., Brown, J., & West, R. (2014). Prospective cohort study of the effectiveness of smoking cessation treatments used in the "real world". *Mayo Clinic Proceedings, 89*(10), 1360-1367. doi:10.1016/j.mayocp.2014.07.004

Kurtz, E., & White, W. (2015). Recovery spirituality. *Religions*, *6*, 58–81. doi:10.3390/rel6010058

Laudet, A. B., Morgen, K., & White, W. L. (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 problems. *Alcoholism Treatment Quarterly, 24*(1-2), 33-73. doi:10.1300/J020v24n01_04

Lemon, S. C., Friedmann, P. D., & Stein, M. D. (2003). The impact of smoking cessation on drug abuse treatment outcome. *Addictive Behaviors, 28*, 1323-1331. doi:10.1016/S0306-4603(02)00259-9

McCarthy, W. J., Collins, C., & Hser, Y. I. (2002). Does smoking cessation effect drug abuse treatment? *Journal of Drug Issues*, *32*, 61-80.

Meysamie, A., Ghaletaki, R., Haghazali, M., Asgari, F., Rashidi, A., Khalilzadeh, O.,…Abbasi, M. (2010). Pattern of tobacco use among the Iranian adult population: results of the national Survey of Risk Factors of Non-Communicable Diseases (SuRFNCD-2007). *Tobacco Control*, *19*(2), 125-128. doi:10.1136/tc.2009.030759

Meysamie, A., Ghaletaki, R., Zhand, N., & Abbasi, M. (2012). Cigarette smoking in Iran. *Iranian Journal of Public Health*, *41*(2), 1-14.

Ong, M. K., Zhou, Q., & Sung, H-Y. (2011). Primary care providers advising smokers to quit: Comparing effectiveness between those with and without alcohol, drug, or mental disorders. *Nicotine & Tobacco Research, 13*, 1193-1201. doi:10.1093/ntr/ntr167

Pagano, M. E., Post, S. G., & Johnson, S. M. (2011). Alcoholics Anonymous-related helping and the helper therapy principle. *Alcoholism Treatment Quarterly, 29*(1), 23-34. doi:10.1080/07347324.2011.538320

Prochaska, J. J., Delucchi, K., & Hall, S. M. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. *Journal of Consulting and Clinical Psychology*, *72*(6), 1144-1156. doi:10.1037/0022-006X.72.6.1144

Raupach, T., Brown, J., Herbec, A., Brose, L., & West, R. (2013). A systematic review of studies assessing the association between adherence to smoking cessation medication and treatment success. *Addiction*, *109*(1), 35-43. doi:10.1111/add.12319

Riessman, F. (1965). The “helper” therapy principle. *Social Work*, *10*(2), 27-32. doi: 10.1093/sw/10.2.27

Satre, D. D., Kohn, C. S., & Weisner, C. (2007). Cigarette smoking and long-term alcohol and drug treatment outcomes: A telephone follow-up at five years. *American Journal on Addictions, 16*, 32-37. doi: 10.80/10550490601077825

Shahrokhi, S., Kelishadi, R., Sarrafzadegan, N., Khosravi, A., Roohafza, H. R., Pooya, A., & Mollabashi, R. (2008). Evaluation of the Quit and Win contest for smoking cessation in the Islamic Republic of Iran. *Eastern Mediterranean Health Journal*, *14*(6), 1270-1279.

Siahpush, M., Shaikh, R.A., McCarthy, M., Sikora Kessler, A., Tibbits, M., & Singh, G. K. (2015). Association between duration of use of pharmacotherapy and smoking cessation: findings from a national survey. *BMJ Open, 5*(1), e006229. doi:10.1136/bmjopen-2014-006229

Sobell, M. B., Sobell, L. C., & Kozlowski, L. T. (1995). Dual recoveries from alcohol and smoking problems. In J. B. Fertig & J. A. Allen (Eds.), *Alcohol and tobacco: From basic science to clinical practice* (NIAAA Research Monograph No. 30, pp. 207-224). Rockville, MD: NIAAA.

Stead, L. F., & Lancaster, T. (2012a). Behavioural interventions as adjuncts to pharmacotherapy for smoking cessation. *Cochrane Database of Systematic Reviews*, *12,* CD009670. doi:10.1002/14651858.CD0096703.pub2

Stead, L. F., & Lancaster, T. (2012b). Combined pharmacotherapy and behavioural interventions for smoking cessation. *Cochrane Database of Systematic Reviews*, *10*, CD008286. doi:10.1002/14651858.CD008286.pub2

Stead, L. F., Perera, R., Bullen, C., Mant, D., Hartmann-Boyce, J., Cahill, K., & Lancaster, T. (2012). Nicotine replacement therapy for smoking cessation. *Cochrane Database of Systematic Reviews*, *11*, CD000146. doi:10.1002/14651858.CD000146.pub4

Stuyt, E. B. (1997). Recovery rates after treatment for alcohol/drug dependence. Tobacco users vs. non-tobacco users. *American Journal of Addiction, 6*(2), 159-167. doi:10.1111/j.1521-0391.1997.tb00565.x

USDHHS (U.S. Department of Health and Human Services, 2001). *Women and smoking: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Center for Disease Prevention and Health Promotion, Office on Smoking and Health.

USDHHS (U.S. Department of Health and Human Services, 2004). *The health consequences of smoking: A report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

White, W. L. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.

White, W. L. (2008). Alcohol, tobacco and other drug use by addictions professionals: Historical reflections and suggested guidelines. *Alcoholism Treatment Quarterly, 26*(4), 500-535. doi:10.1080/07347320802347228

White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL Great Lakes: Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

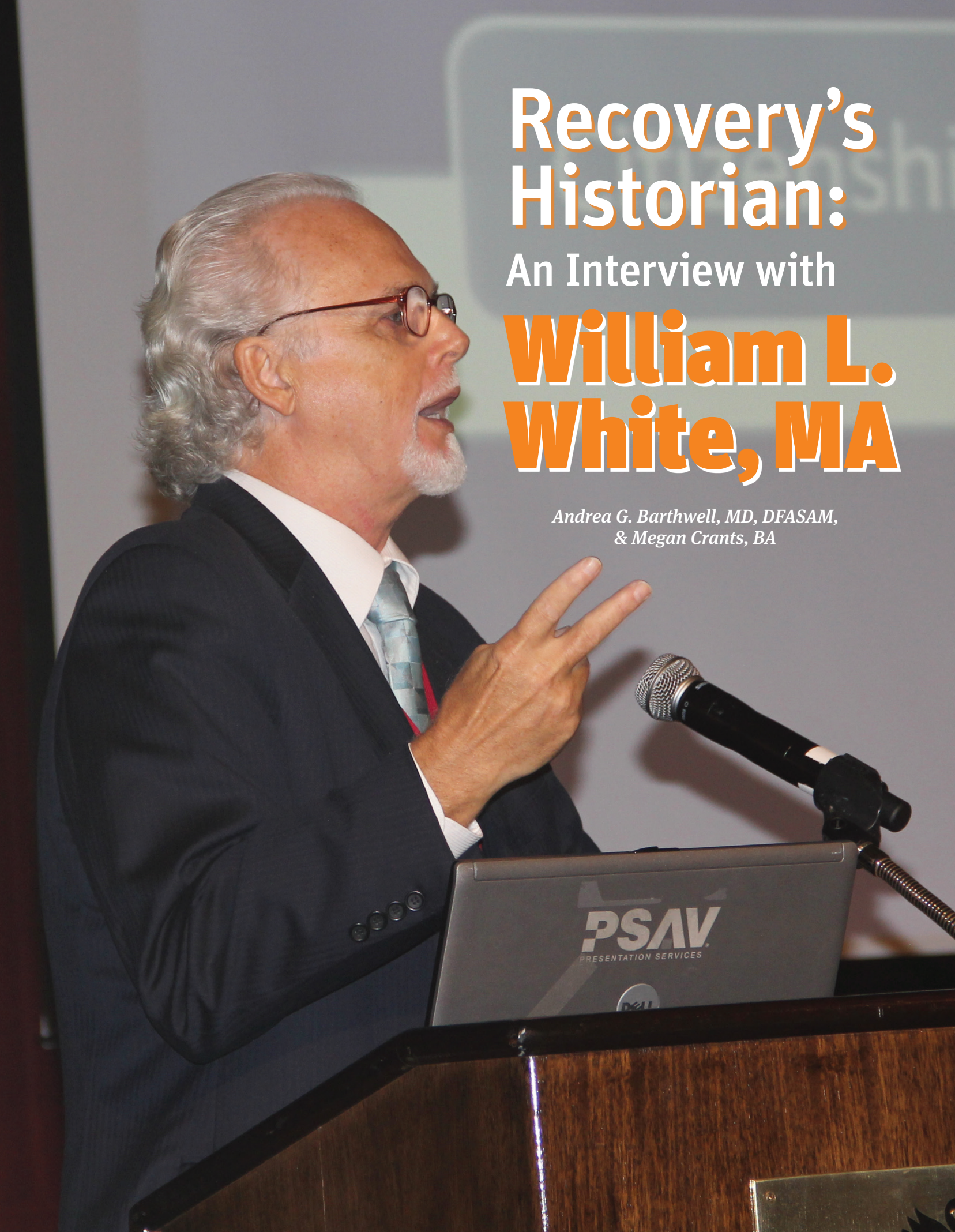
White, W. L. (2012). Smoking cessation within a recovery community: An interview with Hossein Dezhakam, Congress 60, Iran. Retrieved February 18, 2015 from **www.williamwhitepapers.com**.

White, W. L. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. (second edition). Bloomington, IL: Chestnut Health Systems.

White, W. (2015). Congress 60: An addiction recovery community within the Islamic Republic of Iran. *Alcoholism Treatment Quarterly,* 33(3), 328-347. doi: 10.1080/07347324.2015.1050929 .

Wray, J. M., Gass, J. C., & Tiffany, S. T. (2013). A systematic review of the relationships between craving and smoking cessation. *Nicotine & Tobacco Research*, *15*(7), 1167-1182. doi:10.1093/ntr/nts268

Zwar, N. A., Richmond, R. L., Halcomb, E. J., Furler, J. S., Smith, J. P., Hermiz, O.,…Borland, R. (2015). Quit in general practice: a cluster randomized trial of enhanced in-practice support for smoking cessation. *Family Practice, 11*(59). doi:10.1186/1471-2296-11-59



Recovery's Historian:

An Interview with

William L. White, MA

Andrea G. Barthwell, MD, DFASAM,
& Megan Crants, BA

RECOVERY'S HISTORIAN

The antiquated flyer's headline, "Inebriate Asylum, 1876," caught his eye by chance as he wandered the aisles of a local flea market. He paused when he saw the date, surprised. "I've been in the field for four to five years," he thought. "How did I not know that addiction treatment programs existed as early as the 1800s?"

That 1974 flea market discovery led William "Bill" L. White on a thirty-year-long journey of in-depth interviews, historical investigations, and countless significant contributions to the field of addiction. "I just fell in love with the history of the field and all the bizarre, inspirational stories," White explained. "I never would've predicted that I would've been doing this comprehensive work decades later, but that's kind of how it unfolded—I caught the history bug."

Like many people entering the addiction field in the late 1960s, White was drawn in by personal and family recovery experiences. He held his first field position with the Illinois Department of Mental Health, during which time he got a profound look at the deplorable conditions that defined institutions in those days. Seeing the straitjackets, smelling the corridors full of urine, hearing about the forced sterilizations . . . his senses overwhelmed him and turned him towards a passion for changing the world for the better. When asked about navigating the field from that point on, White responded,

> *I wish I could've said all of this was planned, but much of it was totally by accident. As I began to develop a deep passion for the work, I found vacuums of need or things that weren't being addressed and sometimes just got invited to come in and be part of solving some of those vacuums, whether it was in early areas of clinical treatment combining alcoholism and treatment of other addictions, or early issues related to ethics of addiction counseling, or some of the early organizational problems treatment programs were faced with . . . I just kind of stumbled in and did what I could during the process. There are all these specialty roles I've had over the course of my career, but in retrospect I didn't really choose . . . they sort of chose me.*

Some of White's earliest and most significant contributions revolve around the culture of addiction and recovery. White clinically examined the way in which people made the journey between the two worlds, then continued on to write ethical case studies for the field. His later contributions were primarily in the historical arena, exploring the enormous opportunity he and the other pioneers had to shift addiction treatment from an acute model of biopsychosocial stabilization to models of sustained recovery management. Today he is working to chronicle activities on the frontier of the recovery movement.

One early pioneer, Ed Senay, MD, served as a mentor for White's master's in addiction studies program in the late 1970s. White attributes much of his maturation in the field to Senay and recounted one of his most vivid memories:

> *I had come out of a therapeutic community, Twelve-Step-oriented treatment background when I began my work in school, and I think it was either the second or third session that I met with Ed. Somehow the subject of methadone came up and I went into one of my antimethadone rants that I was giving at that point in my young, naïve career. Ed very patiently let me wind down this bizarre rant that I was giving, then he looked at me and said, "Young man, your passion is in inverse proportion to your knowledge." He began to pull books off his shelf for me and that was sort of the beginning of my maturation and my immersion into the science of the field.*

White is perhaps best known for his book *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Published in 1998, the book is true to White's ideals of shared stories and lessons, and details the evolution of the field with inspiring insights about some of the pioneers who made addiction treatment possible. White didn't just stop there, though; he went on to produce over four-hundred journal articles, book chapters, and interviews during his career and will be remembered as a man who truly made a difference through his careful research and writing skills. When asked about his process, White humbly replied that he learned about some of the most important aspects of writing through his mentor Ernie Kurtz. He recalled trips to Ann Arbor, Michigan and sitting in Kurtz's basement, where the two men would bounce questions and ideas off of each other in a classically Socratic manner:

> *He taught me a lot about the mechanics of telling stories: telling them in sequence, making sure you have the evidence to support those stories, making sure you looked at all of the evidence, the importance of telling untold stories, how to personalize and put stories in historical context . . . when I asked him to advise on the AA chapters of* Slaying the Dragon *I had no idea that it would morph into this larger mentorship on conducting historical research, and I had no idea that we would go on to do a number of collaborations together.*

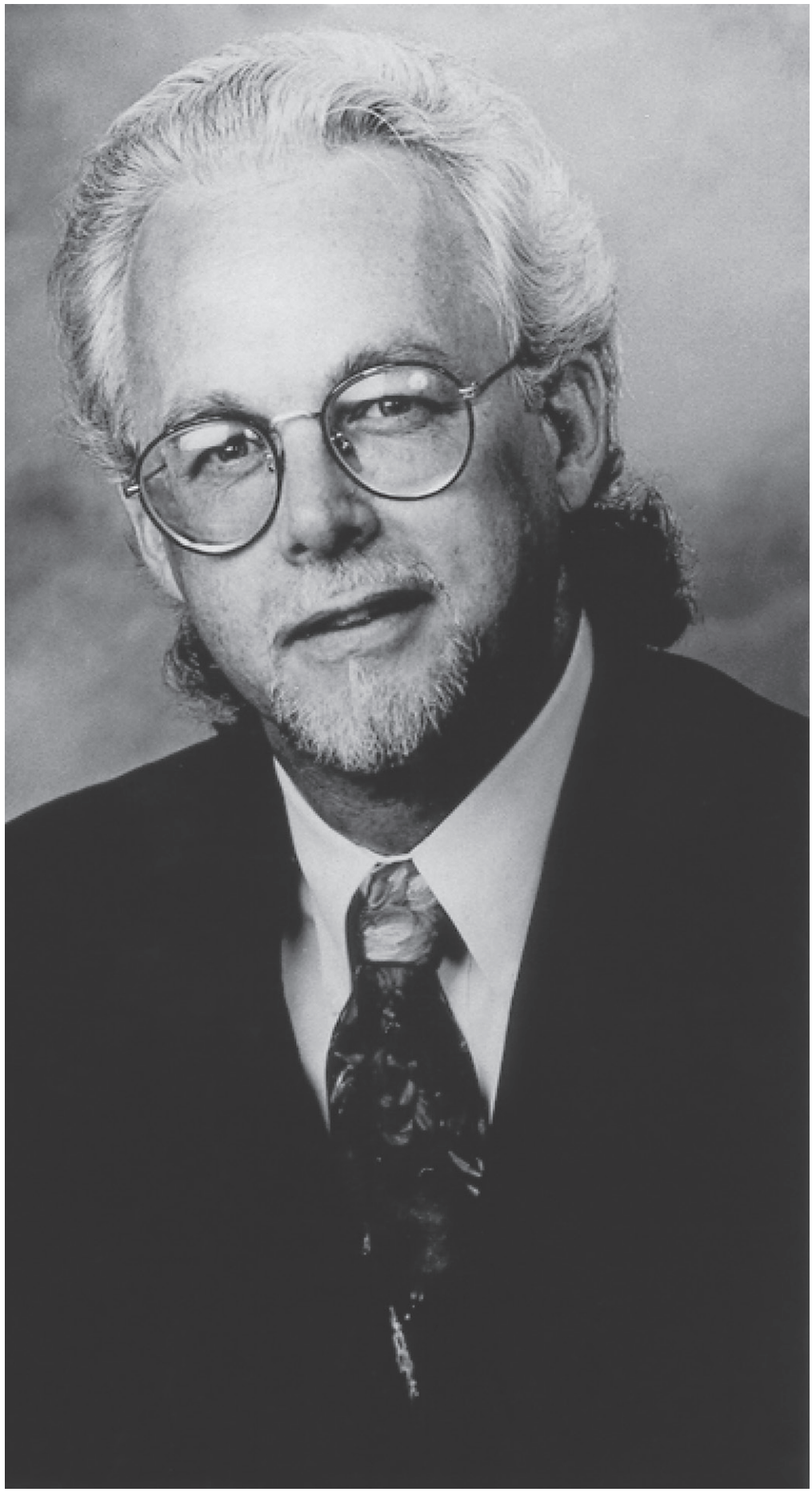
White began writing for *Counselor* magazine in 1999, translating his extensive knowledge of the field into a regular column about the history of treatment and recovery in the United States; "mapping this thing we call recovery."

Some of his articles translated research to practice, others explored treatment options in addiction counseling, and several of them were commentaries on controversial issues like confrontation and expulsion from treatment centers. In later years, White turned the focus to other pioneers in the field in an interview-format spotlight series. "As I got older and a lot of people that had mentored me began to pass on, this series was a way to take some of those individuals and honor them," said White. "Part of my involvement has been to tell some of the organizational histories . . . but I always come back to the fact that so much of the field involves personal stories that these people have told as they've shaped the field over the last half century," he added.

White entered the academic realm of historians from a clinical treatment background and initially found himself intimidated by the scholastic experience of his colleagues. One of White's mentors, David Musto, PhD, was quick to assure him, however, that his clinical perspective was crucial to recording the history of treatment. Musto reminded White that the academics were just as overwhelmed as he was because of his exposure to the "real world" of addiction and recovery. "I remember him as this sort of grand gentleman who was just enormously supportive of someone who didn't have as many of the academic credentials of other people who he was mentoring," White reminisced. "He was wonderfully supportive and convinced me how important this research was that I was doing . . . how nobody really told the full history of treatment and that perhaps I could help fill that vacuum," he said.

In filling that vacuum, White broke down barriers between academics and clinicians in order to form a more united community of addiction historians. "I've often found myself in the middle, looking at polarized issues and looking at ways to bring some of the constituencies from those groups together . . . I think I've been kind of a bridge builder as part of my role within the field," he explained.

Even with all of his success, White remains modest and eager to learn:



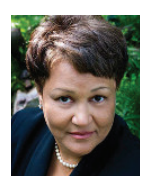


I think staying a student has been very important throughout this process. I'm at an age now where everybody tends to think of me in terms of a teacher or mentor role, but it's really strange because I really am humbled daily by what we still need to know and what we don't know. I've really enjoyed being a student of this rapidly expanding recovery advocacy movement, and seeing all the new recovery support institutions beyond addiction treatment that are spreading as a result of that movement.

While it is true that the field looks upon White's body of work and understands what he represents and how he represents us, when you are in his presence you feel his vitality and always appreciate his fresh take on where we are now. He knows we have come a long way from the late nineteenth century services that caught his eye almost a half century ago, but that we have a long way still to go.

As he retires from writing his articles for *Counselor* to dedicate his time and interests in other ways on our behalf, I am proud to step into this space and continue the conversation. I am joined by my associate, Megan Crants, in this work. We would love to hear from you and will use your communication as inspiration for what we cover. I once dreamed about being a journalist and I am thrilled to step into the shoes that my long-term friend Bill has left behind.

About the Authors



Andrea G. Barthwell, MD, FASAM, is an internationally renowned physician that has been a pioneer in the field of addiction medicine within the American Addiction Society of Medicine (ASAM) and a contributor to the field of alcoholism and addiction treatment. She is a past president of ASAM, was awarded fellow status, and is certified by the American Board of Addiction Medicine (ABAM). Dr. Barthwell currently serves as the medical director for Encounter Medical Group, PC, and is the founder and CEO of the Two Dreams facilities.



Megan Crants, BA, graduated from Johns Hopkins University in 2014 with degrees in cognitive science and writing seminars. She is currently a clinical associate and head writer/editor at Two Dreams in Chicago.

References

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: 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: White, W. (2019). The recovery revolution: Its critical ingredients. Posted at **www.williamwhitepapers.com**

The Recovery Revolution: Its Critical Ingredients

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The second edition of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* includes a chapter entitled "The Recovery Revolution." What exactly is the nature of this "revolution" in thinking and practice? What distinguishes it from earlier responses to alcohol and other drug (AOD) problems? Recovery is by no means a new phenomenon as *Slaying the Dragon* meticulously details, but there are recent fundamental shifts within the AOD problems arena that are of potentially significant historical import. Critics of recovery advocacy have sometimes claimed that recovery advocacy, recovery management, recovery-oriented systems of care, and related ideas and initiatives are just a "flavor of the month" passing fad and that there is no "recovery revolution." This brief outline below suggests ten foundational shifts that will dramatically affect the future of addiction treatment and recovery in the United States and beyond.

I. International Growth and Diversification of Recovery Mutual Aid Organizations

A. International growth of 12-Step programs

- Anomaly of explosive NA growth within the Islamic Republic of Iran since its beginnings there in 1990 (NA presently hosts 70,065 meetings in 139 countries; of these, 27,677 (40%) are in the United States, and 22,613 (32%) are in Iran. NA members in Iran now consume more NA literature than the rest of the world combined.) (Source: Email Communication with Rebecca Meyer, NA World Services, July 19, 2018; Galanter, White, & Hunter, Cross-cultural applicability of the Twelve Step model: A comparison of Narcotics Anonymous in the USA and Iran, in press, *Journal of Addiction Medicine*)
- Advent of drug-specific 12-Step groups in response to particular drug surges, e.g., *Crystal Meth Anonymous*, Heroin Anonymous, Opiates Anonymous
- Continued adaptation of AA Steps to address problems other than addiction (endless permutations)

B. Growth of special interest groups within 12-Step programs, e.g., for women, young people, LGBTQ, Spanish and other languages, etc.

- Growth of secular meetings within 12-Step groups, e.g., Atheists and Agnostics in AA (Quad A), AA Agnostica, and recognition of these groups via dedicated issue of the AA Grapevine in October 2016, AA publication of One Big Tent, Atheist and agnostic AA members share their experience, strength and hope, and independent publication of such books as *Do Tell! Stories by Atheists and Agnostics in AA*, *A History of Agnostics in AA*, and Beyond Belief: Agnostic Musings for 12 Step Life

C. Growth of secular and religious alternatives to mainstream 12-Step groups

- Secular groups: Women for Sobriety, Secular Organizations for Sobriety, SMART Recovery, LifeRing Secular Recovery
- Religious groups, including Eleventh Step Groups: Celebrate Recovery, Refuge Recovery, Buddhist Recovery Network, Calix Society, Jewish Alcoholics, Chemical Dependents and Significant Others (JACS), Jewish Recovery Network, Millati Islami

D. Profession-specific recovery support groups, e.g., physicians, health care professionals, pilots, lawyers, food and beverage industry workers (also see Ben's Friends interview Here), musicians, etc.

E. New culturally-specific recovery mutual aid frameworks

- Red Road Wellbriety groups
- Grupo de Cuarto y Quinto Paso (CQ, 4th and 5th Step Groups in Mexico and U.S.)

F. Advent of "big tent" recovery support groups

- All Recovery (AR) groups
- Multiple Pathways of Recovery (MPR) groups
- Methadone Anonymous; Medication Assisted Recovery Anonymous; Drug Addicts Anonymous; Medication Assisted Recovery Support (MARS); Ability, Inspiration and Motivation (AIM); Suboxone Support Group; Moms on Methadone; and other groups with an explicit welcome to people in medication-supported recovery

G. Phenomena of dual citizenship (concurrent participation in two or more mutual aid programs)

H. Stage-influenced changes in recovery affiliation—changes in primary mutual aid affiliation across the stages of recovery (e.g., recovery initiation in AA followed by recovery maintenance through the church) or changes in pattern/intensity of participation (e.g., recovery initiation within a formal mutual aid group followed by disengagement and sustained recovery support via family and friends)

I. New resources for affected families including special groups for grieving family members spawned by rising overdose deaths (e.g., GRASP--Grief after Substance Passing).

J. Recent recognition of large population of people who resolve AOD significant problems without addiction treatment or mutual aid involvement and who do not embrace recovery identity

II. Exponential growth of virtual recovery communities and online recovery support resources

A. Virtual recovery resources as both adjuncts and alternatives to traditional recovery mutual aid societies and addiction treatment services (see Here and Here for review)

B. Resources span online meetings of recovery mutual aid fellowships, moderation groups, online recovery guidance, e-therapy, and other e-recovery support tools

C. Particularly valuable for people lacking local recovery support resources, women, youth, people who experience social anxiety, and people with mobility/travel limitations.

III. Birth and Maturation of a New Recovery Advocacy Movement

A. Proliferation of grassroots recovery community organizations (RCOs) focused on recovery advocacy, peer recovery support services, recovery-focused professional and public education, and public celebration of recovery

B. Increased visibility of RCOs within communities of color (e.g., Atlanta, Dallas, Detroit, Baltimore, etc.; the Wellbriety Movement; Latino Recovery Advocacy), their broader influence on the recovery advocacy movement, and advocacy for new models of treatment and recovery support within communities of color

C. Networking of RCOs through Faces and Voices of Recovery, the Association of Recovery Community Organizations, Facing Addiction with NCADD, and Young People in Recovery

D. Distinctive focus on shaping community and policy environments in which recovery can flourish via such concepts as the ecology of recovery, recovery spaces/landscapes, social contagiousness of recovery, recovery carriers, recovery cascade (Braithwaite, in press) and community recovery (e.g., focus on healing wounds inflicted upon the community by addiction and related problems)

IV. Emergence of an Ecumenical Culture of Recovery

A. Individuals in recovery seeing themselves as a distinct "people" apart from any identification with a mutual aid or treatment organization

B. Increased recognition, acceptance, and celebration of multiple pathways and styles of recovery initiation and maintenance; extolling the value of choice within the recovery process

- Guiding mantra: *Recovery by any means necessary under any circumstances*

C. Emergence of shared recovery culture

- language: purging stigmatizing language, forging a recovery lexicon that transcends language of particular recovery mutual aid organizations
- values that cross secular, spiritual, and religious recovery mutual aid and other recovery support institutions, e.g., humility, respect, tolerance, forgiveness, gratitude, service
- symbols, slogans, recovery advocacy posters, iconic images/tokens/color that signify recovery, e.g., chips, key tags, jewelry, t-shirts, recovery-themed tattoos.
- landmarks, e.g., places linked to the origin or key milestones within one's recovery, e.g., pilgrimages to birthplace of one's recovery fellowship or other landmarks, such as AA members visiting Stepping Stones or Dr. Bob's house (Founder's Day rituals)
- rituals, e.g., home groups, celebrating recovery anniversaries, etc.
- literature that shifts focus from the problem (addiction) or potential interventions (treatment) to the lived solution (recovery experience, prevalence, pathways, styles, and stages of personal and family recovery)
- new genre of recovery-focused (as opposed to addiction-focused) biographies and autobiographies
- recovery lifestyle magazines e.g., Recovery Today, The Sober World, Recovery Campus, Gabriel: Christians in Recovery, InRecovery, Recovery Campus, etc.
- treatment alumni newsletters/magazines, Together Magazine (Hazelden Betty Ford) and such earlier publications as *Findings* (Betty Ford Center, 1998), *Hazelden Voice* (1990), and *Sierra Quarterly* (1998), etc.
- Recovery advocacy newsletters, e.g., *NCADD Amethyst*, *The Voice of Recovery* (Recovery Communities United-Chicago), *FACTUALITY* (Friends of the Addicted for

Comprehensive Treatment–New York City), *The Recovery Herald* (Connecticut Community for Addiction Recovery), *Speak Out*: Lesbian, Gay, Bisexual, and Transgender Voices for Recovery, New York City, *The Ambassador* (Pennsylvania Recovery Organization), and *The Recovery Advocate* of the Substance Abuse and Addiction Recovery Alliance, Fairfax County, VA.

- Attempts to "manualize" recovery via recovery how to guides
- recovery art, e.g., use of photography, painting, sculpture, and other artistic media to convey the recovery experience e.g., Syracuse Recovery Arts Festival and Exhibit or to support recovery of people affected by addiction, e.g.,see Here.
- recovery-themes music, e.g., musicians publically disclosing their recovery status and expressing the recovery experience through their music
- Films focused on recovery experience and recovery advocacy (e.g., The Anonymous People, Generation Found) and recovery film festivals (e.g., Reel Recovery Film Festival, The New Jersey Recovery Film Festival, Rochester Recovery Film Festival, The Art of Recovery Film Festival, FOR-NY Recovery Art Festival, etc.
- recovery-focused theatre projects, e.g., The San Francisco Recovery Theatre, Hilltown Recovery Theatre, Los Angeles Recovery Theatre, Rise 2 Recovery, Improbable Players.
- leisure, e.g., sober vacations, recovery cruises, recovery runners clubs, etc.
- recovery-focused businesses serving the recovery community
- recovery philanthropy, e.g., people in recovery and people effected by addiction/recovery offering financial support to recovery-focused education, service, and advocacy organizations

V. New Recovery Support Institutions

A. New institutions that fall outside the boundaries of the historical recovery mutual aid societies and addiction treatment organizations

- treatment alumni groups
- recovery residences
- recovery high schools
- collegiate recovery programs (for examples, see Here, Here, and Here)
- recovery friendly workplaces
- recovery community organizations (RCOs)
- public recovery celebrations/walks
- recovery community centers
- recovery ministries, recovery churches, and recovery-friendly churches
- recovery cafés
- recovery comedy/improv events (for examples, see Here, Here, and Here)
- recovery music fests, e.g., Rockers in Recovery Music Festivals
- recovery film festivals, e.g., Reel Recovery Film Festival
- recovery book clubs, e.g., Recovery Rising Society, Women in Recovery Book Club
- recovery art shows and coops
- recovery-themed fitness, sport, and adventure clubs, e.g., The Phoenix, Adventure Recovery)
- recovery theatre projects

B. Networking of these institutions through new associations, e.g., National Alliance for Recovery Residences, Association of Recovery Schools, Association of Recovery in Higher Education, Treatment Professionals in Alumni Services, Recovery Café Network, etc.

VI. New Recovery Support Roles/Services

A. Emergence of peer recovery support specialists / recovery coaches

B. Increased federal, state, and local funding for non-clinical, peer-based recovery support services

C. Integration of peer support roles in addiction treatment, primary health care (particularly emergency services), child welfare, criminal justice, and educational settings.

D. Advent of new peer recovery support training programs, credentialing standards, role clarity papers, ethical guidelines, research reviews of peer service effectiveness, manuals on peer supervision, and peer services implementation manuals.

VII. From Acute Models of Addiction Treatment to Models of Sustained Recovery Management (RM) Nested within Larger Recovery-Oriented Systems of Care (ROSC)

A.focus from acute care models of treatment (brief episodes of screen, admit, assess, treat, discharge/graduate) to models of sustain recovery support across the stages of recovery (e.g., precovery, recovery initiation, transition to stable recovery maintenance, enhanced quality of personal/family life in long-term recovery, and efforts to break intergenerational cycles of AOD and related problems)

B. RM & ROSC involve such service design innovations as community engagement and assertive outreach, pre-treatment stabilization, comprehensive and continual person/environment assessment, a focus on asset inventory and asset management, broadening the service team, shifting the locus of service delivery to natural environments of those served, extending dose/duration of services, assertive linkage to recovery community resources, and extended post-treatment recovery checkups.

C. Focus on mobilizing community resources to support long-term personal/family recovery

D. RM & ROSC as an organizing framework for SAMHSA, dissemination through the Addiction Technology Transfer Centers, with increased numbers of states and local communities using RM & ROSC concepts to guide systems transformation efforts.

VIII. Cross-fertilization of Prevention, Harm Reduction, Early Intervention, Treatment, and Recovery Support Services

A. Increased bi-directional Integration of pharmacotherapy and recovery support services in both traditional Twelve Step Treatment Settings and increased integration of peer recovery support services within clinic-based and office-based pharmacotherapy settings and primary health care settings.

B. RCO involvement in primary prevention, street outreach, Narcan distribution, overdose intervention, community education on treatment resources, public information on medication-assisted recovery, intervention, post-treatment recovery checkups, drug courts, child welfare projects, etc.

C. Advent of drug user unions in the U.S. with overlapping advocacy agendas with RCOs and hybrid organizations sharing agendas of RCOs, HR organizations, and drug user unions, e.g., Rebel Recovery.

IX. Recovery-Focused Research

A. Methodologically rigorous studies on the prevalence, pathways, stages, and styles of long-term personal and family recovery

B. Senior and junior research scientists focusing careers on recovery-related research, e.g., Ashford, Bergman, Best, Dennis, Godley, Godley, Greene, Humphreys, Jason, Kaskutas, Kelly, Laudet, Mericle, Polcin, Sanders, Scott, White, etc.

C. Increasing numbers of people in recovery pursuing graduate education with plans to focus on recovery research—all aided by increased numbers of college and university undergraduate and graduate addictions studies programs

D. Increased NIH interest in recovery research

E. New recovery-focused research institutions, e.g., Harvard's Recovery Research Institute

F. New recovery-focused peer reviewed science journals, e.g., Journal of Recovery Science

X. Recovery as an Organizing Paradigm for Drug Policy

A. Organizing center of AOD problems arena extending from exclusive focus on addiction pathology and methods of social and clinical intervention to extracting knowledge and problem resolution strategies from the collective lived experience of people in long-term recovery

B. SAMHSA/CSAT provision of seed funding to RCOs via the Recovery Community Services Program

C. Increased representation of people in recovery within policy positions, e.g., ONDCP, SAMHSA, state and local policy and planning agencies

D. Recovery focus within 2016 Surgeon General Report Facing Addiction in America

E. Inclusion of funding for RCO development and peer recovery support services within in the 2018 Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act



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. (2019). The recovery revolution: Its critical ingredients. Posted at **www.williamwhitepapers.com**

The Recovery Revolution: Its Critical Ingredients

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

The second edition of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* includes a chapter entitled "The Recovery Revolution." What exactly is the nature of this "revolution" in thinking and practice? What distinguishes it from earlier responses to alcohol and other drug (AOD) problems? Recovery is by no means a new phenomenon as *Slaying the Dragon* meticulously details, but there are recent fundamental shifts within the AOD problems arena that are of potentially significant historical import. Critics of recovery advocacy have sometimes claimed that recovery advocacy, recovery management, recovery-oriented systems of care, and related ideas and initiatives are just a "flavor of the month" passing fad and that there is no "recovery revolution." This brief outline below suggests ten foundational shifts that will dramatically affect the future of addiction treatment and recovery in the United States and beyond.

I. International Growth and Diversification of Recovery Mutual Aid Organizations

A. International growth of 12-Step programs

- Anomaly of explosive NA growth within the Islamic Republic of Iran since its beginnings there in 1990 (NA presently hosts 70,065 meetings in 139 countries; of these, 27,677 (40%) are in the United States, and 22,613 (32%) are in Iran. NA members in Iran now consume more NA literature than the rest of the world combined.) (Source: Email Communication with Rebecca Meyer, NA World Services, July 19, 2018; Galanter, White, & Hunter, Cross-cultural applicability of the Twelve Step model: A comparison of Narcotics Anonymous in the USA and Iran, in press, *Journal of Addiction Medicine*)
- Advent of drug-specific 12-Step groups in response to particular drug surges, e.g., *Crystal Meth Anonymous*, Heroin Anonymous, Opiates Anonymous
- Continued adaptation of AA Steps to address problems other than addiction (endless permutations)

B. Growth of special interest groups within 12-Step programs, e.g., for women, young people, LGBTQ, Spanish and other languages, etc.

- Growth of secular meetings within 12-Step groups, e.g., Atheists and Agnostics in AA (Quad A), AA Agnostica, and recognition of these groups via dedicated issue of the AA Grapevine in October 2016, AA publication of One Big Tent, Atheist and agnostic AA members share their experience, strength and hope, and independent publication of such books as *Do Tell! Stories by Atheists and Agnostics in AA*, *A History of Agnostics in AA*, and Beyond Belief: Agnostic Musings for 12 Step Life

C. Growth of secular and religious alternatives to mainstream 12-Step groups

- Secular groups: Women for Sobriety, Secular Organizations for Sobriety, SMART Recovery, LifeRing Secular Recovery
- Religious groups, including Eleventh Step Groups: Celebrate Recovery, Refuge Recovery, Buddhist Recovery Network, Calix Society, Jewish Alcoholics, Chemical Dependents and Significant Others (JACS), Jewish Recovery Network, Millati Islami

D. Profession-specific recovery support groups, e.g., physicians, health care professionals, pilots, lawyers, food and beverage industry workers (also see Ben's Friends interview Here), musicians, etc.

E. New culturally-specific recovery mutual aid frameworks

- Red Road Wellbriety groups
- Grupo de Cuarto y Quinto Paso (CQ, 4th and 5th Step Groups in Mexico and U.S.)

F. Advent of "big tent" recovery support groups

- All Recovery (AR) groups
- Multiple Pathways of Recovery (MPR) groups
- Methadone Anonymous; Medication Assisted Recovery Anonymous; Drug Addicts Anonymous; Medication Assisted Recovery Support (MARS); Ability, Inspiration and Motivation (AIM); Suboxone Support Group; Moms on Methadone; and other groups with an explicit welcome to people in medication-supported recovery

G. Phenomena of dual citizenship (concurrent participation in two or more mutual aid programs)

H. Stage-influenced changes in recovery affiliation—changes in primary mutual aid affiliation across the stages of recovery (e.g., recovery initiation in AA followed by recovery maintenance through the church) or changes in pattern/intensity of participation (e.g., recovery initiation within a formal mutual aid group followed by disengagement and sustained recovery support via family and friends)

I. New resources for affected families including special groups for grieving family members spawned by rising overdose deaths (e.g., GRASP--Grief after Substance Passing).

J. Recent recognition of large population of people who resolve AOD significant problems without addiction treatment or mutual aid involvement and who do not embrace recovery identity

II. Exponential growth of virtual recovery communities and online recovery support resources

A. Virtual recovery resources as both adjuncts and alternatives to traditional recovery mutual aid societies and addiction treatment services (see Here and Here for review)

B. Resources span online meetings of recovery mutual aid fellowships, moderation groups, online recovery guidance, e-therapy, and other e-recovery support tools

C. Particularly valuable for people lacking local recovery support resources, women, youth, people who experience social anxiety, and people with mobility/travel limitations.

III. Birth and Maturation of a New Recovery Advocacy Movement

A. Proliferation of grassroots recovery community organizations (RCOs) focused on recovery advocacy, peer recovery support services, recovery-focused professional and public education, and public celebration of recovery

B. Increased visibility of RCOs within communities of color (e.g., Atlanta, Dallas, Detroit, Baltimore, etc.; the Wellbriety Movement; Latino Recovery Advocacy), their broader influence on the recovery advocacy movement, and advocacy for new models of treatment and recovery support within communities of color

C. Networking of RCOs through Faces and Voices of Recovery, the Association of Recovery Community Organizations, Facing Addiction with NCADD, and Young People in Recovery

D. Distinctive focus on shaping community and policy environments in which recovery can flourish via such concepts as the ecology of recovery, recovery spaces/landscapes, social contagiousness of recovery, recovery carriers, recovery cascade (Braithwaite, in press) and community recovery (e.g., focus on healing wounds inflicted upon the community by addiction and related problems)

IV. Emergence of an Ecumenical Culture of Recovery

A. Individuals in recovery seeing themselves as a distinct "people" apart from any identification with a mutual aid or treatment organization

B. Increased recognition, acceptance, and celebration of multiple pathways and styles of recovery initiation and maintenance; extolling the value of choice within the recovery process

- Guiding mantra: *Recovery by any means necessary under any circumstances*

C. Emergence of shared recovery culture

- language: purging stigmatizing language, forging a recovery lexicon that transcends language of particular recovery mutual aid organizations
- values that cross secular, spiritual, and religious recovery mutual aid and other recovery support institutions, e.g., humility, respect, tolerance, forgiveness, gratitude, service
- symbols, slogans, recovery advocacy posters, iconic images/tokens/color that signify recovery, e.g., chips, key tags, jewelry, t-shirts, recovery-themed tattoos.
- landmarks, e.g., places linked to the origin or key milestones within one's recovery, e.g., pilgrimages to birthplace of one's recovery fellowship or other landmarks, such as AA members visiting Stepping Stones or Dr. Bob's house (Founder's Day rituals)
- rituals, e.g., home groups, celebrating recovery anniversaries, etc.
- literature that shifts focus from the problem (addiction) or potential interventions (treatment) to the lived solution (recovery experience, prevalence, pathways, styles, and stages of personal and family recovery)
- new genre of recovery-focused (as opposed to addiction-focused) biographies and autobiographies
- recovery lifestyle magazines e.g., Recovery Today, The Sober World, Recovery Campus, Gabriel: Christians in Recovery, InRecovery, Recovery Campus, etc.
- treatment alumni newsletters/magazines, Together Magazine (Hazelden Betty Ford) and such earlier publications as *Findings* (Betty Ford Center, 1998), *Hazelden Voice* (1990), and *Sierra Quarterly* (1998), etc.
- Recovery advocacy newsletters, e.g., *NCADD Amethyst*, *The Voice of Recovery* (Recovery Communities United-Chicago), *FACTUALITY* (Friends of the Addicted for

Comprehensive Treatment–New York City), *The Recovery Herald* (Connecticut Community for Addiction Recovery), *Speak Out*: Lesbian, Gay, Bisexual, and Transgender Voices for Recovery, New York City, *The Ambassador* (Pennsylvania Recovery Organization), and *The Recovery Advocate* of the Substance Abuse and Addiction Recovery Alliance, Fairfax County, VA.

- Attempts to "manualize" recovery via recovery how to guides
- recovery art, e.g., use of photography, painting, sculpture, and other artistic media to convey the recovery experience e.g., Syracuse Recovery Arts Festival and Exhibit or to support recovery of people affected by addiction, e.g.,see Here.
- recovery-themes music, e.g., musicians publically disclosing their recovery status and expressing the recovery experience through their music
- Films focused on recovery experience and recovery advocacy (e.g., The Anonymous People, Generation Found) and recovery film festivals (e.g., Reel Recovery Film Festival, The New Jersey Recovery Film Festival, Rochester Recovery Film Festival, The Art of Recovery Film Festival, FOR-NY Recovery Art Festival, etc.
- recovery-focused theatre projects, e.g., The San Francisco Recovery Theatre, Hilltown Recovery Theatre, Los Angeles Recovery Theatre, Rise 2 Recovery, Improbable Players.
- leisure, e.g., sober vacations, recovery cruises, recovery runners clubs, etc.
- recovery-focused businesses serving the recovery community
- recovery philanthropy, e.g., people in recovery and people effected by addiction/recovery offering financial support to recovery-focused education, service, and advocacy organizations

V. New Recovery Support Institutions

A. New institutions that fall outside the boundaries of the historical recovery mutual aid societies and addiction treatment organizations

- treatment alumni groups
- recovery residences
- recovery high schools
- collegiate recovery programs (for examples, see Here, Here, and Here)
- recovery friendly workplaces
- recovery community organizations (RCOs)
- public recovery celebrations/walks
- recovery community centers
- recovery ministries, recovery churches, and recovery-friendly churches
- recovery cafés
- recovery comedy/improv events (for examples, see Here, Here, and Here)
- recovery music fests, e.g., Rockers in Recovery Music Festivals
- recovery film festivals, e.g., Reel Recovery Film Festival
- recovery book clubs, e.g., Recovery Rising Society, Women in Recovery Book Club
- recovery art shows and coops
- recovery-themed fitness, sport, and adventure clubs, e.g., The Phoenix, Adventure Recovery)
- recovery theatre projects

B. Networking of these institutions through new associations, e.g., National Alliance for Recovery Residences, Association of Recovery Schools, Association of Recovery in Higher Education, Treatment Professionals in Alumni Services, Recovery Café Network, etc.

VI. New Recovery Support Roles/Services

A. Emergence of peer recovery support specialists / recovery coaches

B. Increased federal, state, and local funding for non-clinical, peer-based recovery support services

C. Integration of peer support roles in addiction treatment, primary health care (particularly emergency services), child welfare, criminal justice, and educational settings.

D. Advent of new peer recovery support training programs, credentialing standards, role clarity papers, ethical guidelines, research reviews of peer service effectiveness, manuals on peer supervision, and peer services implementation manuals.

VII. From Acute Models of Addiction Treatment to Models of Sustained Recovery Management (RM) Nested within Larger Recovery-Oriented Systems of Care (ROSC)

A.focus from acute care models of treatment (brief episodes of screen, admit, assess, treat, discharge/graduate) to models of sustain recovery support across the stages of recovery (e.g., precovery, recovery initiation, transition to stable recovery maintenance, enhanced quality of personal/family life in long-term recovery, and efforts to break intergenerational cycles of AOD and related problems)

B. RM & ROSC involve such service design innovations as community engagement and assertive outreach, pre-treatment stabilization, comprehensive and continual person/environment assessment, a focus on asset inventory and asset management, broadening the service team, shifting the locus of service delivery to natural environments of those served, extending dose/duration of services, assertive linkage to recovery community resources, and extended post-treatment recovery checkups.

C. Focus on mobilizing community resources to support long-term personal/family recovery

D. RM & ROSC as an organizing framework for SAMHSA, dissemination through the Addiction Technology Transfer Centers, with increased numbers of states and local communities using RM & ROSC concepts to guide systems transformation efforts.

VIII. Cross-fertilization of Prevention, Harm Reduction, Early Intervention, Treatment, and Recovery Support Services

A. Increased bi-directional Integration of pharmacotherapy and recovery support services in both traditional Twelve Step Treatment Settings and increased integration of peer recovery support services within clinic-based and office-based pharmacotherapy settings and primary health care settings.

B. RCO involvement in primary prevention, street outreach, Narcan distribution, overdose intervention, community education on treatment resources, public information on medication-assisted recovery, intervention, post-treatment recovery checkups, drug courts, child welfare projects, etc.

C. Advent of drug user unions in the U.S. with overlapping advocacy agendas with RCOs and hybrid organizations sharing agendas of RCOs, HR organizations, and drug user unions, e.g., Rebel Recovery.

IX. Recovery-Focused Research

A. Methodologically rigorous studies on the prevalence, pathways, stages, and styles of long-term personal and family recovery

B. Senior and junior research scientists focusing careers on recovery-related research, e.g., Ashford, Bergman, Best, Dennis, Godley, Godley, Greene, Humphreys, Jason, Kaskutas, Kelly, Laudet, Mericle, Polcin, Sanders, Scott, White, etc.

C. Increasing numbers of people in recovery pursuing graduate education with plans to focus on recovery research—all aided by increased numbers of college and university undergraduate and graduate addictions studies programs

D. Increased NIH interest in recovery research

E. New recovery-focused research institutions, e.g., Harvard's Recovery Research Institute

F. New recovery-focused peer reviewed science journals, e.g., Journal of Recovery Science

X. Recovery as an Organizing Paradigm for Drug Policy

A. Organizing center of AOD problems arena extending from exclusive focus on addiction pathology and methods of social and clinical intervention to extracting knowledge and problem resolution strategies from the collective lived experience of people in long-term recovery

B. SAMHSA/CSAT provision of seed funding to RCOs via the Recovery Community Services Program

C. Increased representation of people in recovery within policy positions, e.g., ONDCP, SAMHSA, state and local policy and planning agencies

D. Recovery focus within 2016 Surgeon General Report Facing Addiction in America

E. Inclusion of funding for RCO development and peer recovery support services within in the 2018 Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act



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: Passetti, L., Greene, L., White, W., & Godley, M. (2019) The volunteer recovery support for adolescents (VRSA) experiment: Design and implementation. *Journal of Substance Abuse Treatment*, 98, 1-8. https://doi.org/10.1016/j.jsat.2018.11.015 (doi: 10.1016/j.jsat.2018.11.015) Posted at **www.williamwhitepapers.com**

The volunteer recovery support for adolescents (VRSA) experiment: Design and implementation

Conclusion

"VRSA is a flexible, potentially low-cost model for providing recovery support services that is acceptable to adolescents and effective, especially at higher session completion rates (Godley et al., 2019 in this issue). Recruiting, retaining, training, and supervising volunteers proved both feasible and sustainable over nearly 4years during this research. Students in colleges and universities proved a readily available source of volunteers for VRSA, thus overcoming a typical obstacle to sustaining volunteer service programs over time. Importantly, volunteers (most of who were not in recovery) were able to successfully implement the model with fidelity."



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. (2021). The new recovery advocacy movement: A twenty-year retrospective. Opening Keynote Address, 20th Anniversary Recovery Summit, Faces and Voices of Recovery, October 3-6, 2021. Posted at www.williamwhitepapers.com

The New Recovery Advocacy Movement: A Twenty-year Retrospective

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Introduction

It is a pleasure and honor to be with you this morning to commemorate 20th anniversary of the St. Paul Recovery Summit that launched a new recovery advocacy movement in the United States. I would like to dedicate my remarks this morning to the recovery advocates we've lost since we first gathered in St. Paul, and particularly to those we've lost to COVID these past two years. The pandemic starkly exposed the legacy of physical vulnerabilities many of us bring into the recovery experience. As much as we wanted to be together for this event, it was a wise decision to protect our people by shifting this commemoration to a virtual platform.

In my earlier writings and presentations, I have explored the history of the new recovery advocacy movement, including the history and import of the 2001 Recovery Summit. I have celebrated the contributions of the individuals and organizations that were so critical to that event. And I have addressed the many challenges we've faced as a movement since that historic meeting. This morning, I am going to highlight seven major achievements of the recovery advocacy movement since 2001 and offer a few closing reflections on the future of recovery advocacy.

1. Toward a Recovery Paradigm

Our first achievement is in elevating and celebrating the very idea of recovery. For more than 200 years, approaches to alcohol and other drug (AOD) problems in the United States focused on the prevalence of AOD-related problems and their related pathologies as well as their related social, legal, and medical interventions. Throughout these years, recovery, the lived personal solution to such problems, has for the most part remained culturally and professionally

invisible. Twenty years ago, we sent a clarion call to shift the organizing center of the addictions field from one of pathology and clinical intervention to a focus on the lived experience of long-term personal and family recovery. We did so through four core propositions.

We proclaimed: recovery is a reality for individuals, families and communities; and later added that it could also be extraordinary—far more than removal of AOD from otherwise unchanged life. We boldly proclaimed, "We are the evidence—the living proof of the hope and reality of long-term recovery.

We suggested that there are multiple pathways and styles of recovery and we professed that ALL such pathways and styles are cause for celebration.

We asserted that people who have been part of the problem can, in recovery, be part of the solution.

We affirmed that recovery flourishes in supportive communities. We made recovery contagious as we made it visible and accessible in our local communities. We unleashed legions of recovery carriers who embodied that solution—giving hope to individuals, families and communities that were still suffering. Extending the focus to include cultural and community recovery contexts turned out to have profound implications.

We have made significant progress in moving towards this solutions focus. Resistance, resilience, and recovery are emerging as alternative organizing concepts for policy, planning, and funding bodies. We see this reflected in:

- landmark legislation: the Mental Health Parity and Addiction Equity Act, the Affordable Care Act (ACA), the Comprehensive Addiction and Recovery Act of 2015 (CARA) and in currently pending legislation,
- the dismantling of key discriminatory laws and regulations that have posed obstacles to recovery,
- the elevation of recovery as a valuable organizing paradigm at ONDCP, SAMHSA/CSAT, and within state planning/funding authorities, and in
- the attention to recovery within the National Drug Strategy and in reports from the U.S. Surgeon General.

Focusing on the solution rather than the problem seemed like a simple suggestion to us 20 years ago, but it turns out that recovery is a quite revolutionary and a catalyst for fundamental changes in public policy and service practices.

There would be no talk today of recovery definitions, recovery prevalence, recovery capital, recovery management, recovery-oriented systems of care, recovery community organizations, recovery coaches, stages of recovery, varieties of recovery experience, or culture of recovery if the core concept of recovery had not been pushed into central prominence within the addictions field. Similarly, the progress we have made confronting addiction-related stigma has rested on the centrality of the recovery concept. This is our first and foremost achievement.

Mass Mobilization of People in Recovery

Our vision 20 years ago was to achieve the cultural and political mobilization of people in recovery and their families and allies. We have made substantial achievements toward that goal. We have done that through grassroots organizing, recovery-focused political lobbying, new social media outlets, recovery messaging training, recovery conferences, and through local and

national recovery celebration events—from recovery marches to American Honors Recovery. Our numbers are growing and the leadership roles of women, young people, people of color, members of the LGBTQ communities, and other historically marginalized communities, as well as members of diverse recovery communities, have increased the inclusiveness of our efforts. We are becoming what Carol McDaid calls a constituency of consequence. The 2001 Summit set the stage for those mobilization efforts.

A New Sense of Peoplehood

New kinetic ideas and grassroots mobilization efforts triggered an unprecedented milestone: the self-recognition of individuals in recovery as a distinct "people" beyond their identification with a particular mutual aid organization or treatment institution. The historical significance of this sense of "peoplehood" cannot be overstated. Stigmatized populations often express internalized stigma through personal scapegoating and splintering themselves into warring factions. Today, people from diverse pathways of recovery are seeing themselves collectively as "a people" with a unique history, distinctive challenges, a shared destiny, and shared service opportunities. It would have been inconceivable to me when I began this service ministry in the 1960s that I would one day see tens of thousands of people from diverse pathways of recovery marching arm-in-arm publically through the main streets of U.S cities. We have lived to witness that unlikely miracle.

Recovery Institution Building

There is always the risk in social change movements that we briefly energize people without building institutions to support sustained social change. That is when social change efforts quickly rise and fall. We have avoided that pitfall by supporting the growth of new recovery support institutions.

We have supported the national and international growth and diversification of recovery mutual aid societies and online recovery communities.

We have led the rise of the RCO as new type of community institution—different from AOD councils, different from recovery mutual aid fellowships, and different from prevention and treatment organizations. The RCOs and their linkage through Faces and Voices of Recovery and the Association of Recovery Community Organizations have served as the grassroots infrastructure for all we have since achieved and have spurred the further growth of national and local recovery advocacy efforts.

We have supported the growth of new recovery community institutions: recovery residences, recovery high schools and collegiate recovery programs, recovery friendly workplaces, occupation-based recovery support programs, recovery community centers, online recovery communities, recovery ministries, recovery cafes, recovery ministries, recovery book clubs, and recovery-focused activities in music, art, literature, history, media, film, theatre, fitness, sports, adventure, and entertainment.

We are creating the physical, psychological and social space in local communities in which long-term recovery can flourish. We have begun the process of building new recovery support institutions and birthing recovery space within local neighborhoods and forging recovery space within every major social institution. This remarkable achievement will progress and reap rewards for decades to come.

Recovery Cultural Production

We have helped birth an ecumenical culture inclusive of multiple pathways and styles of recovery across diverse populations and cultural contexts. We are representing recovery through recovery-focused values, stories, symbols, rituals, literature, history, art, music, dance, photography, and on and on. We are using elements of this cultural production to challenge the language, images, and beliefs that have historically objectified and demonized us, and we are injecting new recovery-focused ideas, language, and images into public and professional arenas.

There is also an emerging recovery ethic and esthetic guiding such cultural production. There is growing consensus that recovery cultural production must:

- spring from us—meaning that it is rooting in recovery communities and recovery ancestors,
- be produced by us—meaning that it is drawn from our experiential knowledge,
- be for and about us—it must serve as a balm for our wounds as well as a call to service
- reflect both our diversity and our unity, and
- be owned by us—meaning that the resources generated are returned to rather than drained from recovery communities.

Such an ethic can assure the integrity and inclusiveness of the recovery culture and minimize the risk of its exploitation.

We are building a world that welcomes recovery and expands the cultural space in which it can survive and thrive.

Recovery and the Continuum of Care

When I first entered this work, there were early calls for a continuum of care within local communities, which at that time meant prevention, which focused on suppressing youthful drug use, and treatment, which then focused on care for those in the latest stages of addiction. We later added early intervention programs and harm reduction programs. What we have done for the first time is added recovery as a distinct arena within the AOD problems service continuum and then sought the infusion of recovery perspectives into all other areas of this service continuum. The danger is that recovery will become a new silo just as prevention, harm reduction, early intervention, and treatment now exist as separate fields/industries. Recovery as a concept and as a menu of support services must instead be fully enmeshed within all of these arenas if there is to exist a true “continuum of care.” We are championing calls to integrate primary prevention, harm reduction, early intervention, addiction treatment, and sustained stage-appropriate recovery support services. We need representation in all of these arenas. Here’s why.

Prevention: No effective strategy for preventing the most severe, complex and chronic AOD problems can exist that fails to recognize the intergenerational transmission of addiction and related problems. The families and children of addicted and recovering people must be elevated as a priority population for prevention efforts. Effective prevention requires public modeling of responsible AOD decision-making that includes the choices of responsible use and, for our most vulnerable and health-conscious populations, the choice of abstinence. People in recovery can play an important role in breaking these intergenerational cycles and modeling abstinence as a personal and social value. People in recovery are at present the most untapped prevention resource. As recovery advocates, we need to be at the prevention policymaking tables and involved in the delivery of frontline prevention services.

Early Intervention: Unfortunately, the natural course of addiction can progress for many years before people seek help and initiate sustainable recovery. Shortening addiction careers and extending recovery careers would be a boon to affected individuals, families, and communities, but this would necessitate sophisticated, assertive, and recovery-focused educational and outreach efforts. Such efforts would also require models of problem resolution and recovery support for people with lower levels of problem severity, complexity, and duration. Achieving this would require increasing the visibility and accessibility of recovery within all major social institutions, including government, finance, business and industry, education, religion, health care, media, entertainment, criminal justice, and child welfare. People modeling multiple pathways and styles of recovery across diverse cultural contexts can play an important role in this process of community education, early engagement, and recovery support.

Harm Reduction: Dead people don't recover. People need different supports at different stages of their addiction and recovery careers. Those two propositions mark the rational for recovery advocates' support of and involvement in various HR activities. We need to meet people where they are, but not leave them there without expanded choices. We can both prevent harm and promote the capacity to flourish. We cannot offer sustained support on people's journey from surviving to thriving if we turned our backs on them when they were at the height of their suffering. By integrating HR and recovery perspectives, we can reduce the damage people inflict on themselves and other and reduce the baggage that they carry with them into the recovery process. We can sustain life, enhance the quality of life, and expand choices for people at the "precovery" stage of their addiction and recovery careers. There will always exist a degree of tension between HR and recovery advocates, but we both serve our constituencies best in collaboration rather than in conflict and isolation.

Treatment: At the dawn of the twenty-first century, a growing number of recovery advocates felt that addiction treatment had become detached from the larger and more enduring process of addiction recovery and that treatment organizations had become disconnected from the grassroots communities out of which they were birthed—more concerned with professional prestige and profit than recovery. We were also concerned with the revolving door of addiction treatment in which people with severe, complex and prolonged addiction careers were being recycled through ever-briefer episodes of treatment and then blamed when they experienced addiction recurrence. We viewed such recurrences more as a system failure than as personal failures.

We called for efforts to extend addiction treatment from models of acute care to models of sustained recovery management (RM) nested within larger recovery oriented systems of care (ROSC). RM/ROSC represent a radical redesign of addiction treatment and the training of addiction professionals. Many such efforts are now underway in great part due to our advocacy and our increased involvement in shaping treatment policy.

Recovery Support: We have been the vanguard in the proliferation of peer recovery support services as an adjunct and alternative to addiction treatment, We know that levels and types of support vary significantly across levels of problem severity and across the long-term stages of recovery. In response, we have added recovery support as a distinct element of the continuum of care for AOD problems. It is now time to fully infuse recovery across this continuum of care and across the stages of long-term personal and family recovery. This will be achieved when there is a designated federal and state funding stream for recovery support services.

The key in thinking of this service and support continuum is to focus on all stages of addiction and recover. This includes the stages of precovery, recovery initiation and maintenance, enhancement of global personal and family health in long-term recovery, and efforts to break intergenerational cycles of addiction and related problems

Toward a Recovery Research Agenda

Finally, we have witnessed the emergence of scientific research focused on the prevalence, stages, styles, and processes of addiction recovery across diverse populations and cultural contexts. We have supported:

- the legitimization of recovery as an important arena for scientific investigation,
- an increase in scientists specializing in recovery research, including people in recovery seeking advanced education to pursue recovery research,
- the rising prominence of recovery-focused research organizations,
- an increased recovery focus within peer-reviewed scientific journals, and
- the expanding recovery research portfolios at NIAAA and NIDA.

People in recovery and our allies are now pioneering a new science of addiction recovery. In 2000 shortly before the Summit, I conducted a literature search and prepared a bibliography of recovery-focused research studies. That bibliography was less than 15 pages long. A similar bibliography on addiction or on treatment at that time would easily have been more than a thousand pages. Today, that recovery research bibliography is more than 400 pages. This is a remarkable achievement that will reap enormous rewards in the years to come.

Progress Summary: The achievements I have outlined would have been unthinkable to many of us attending the 2001 recovery summit. Yes, through our efforts we have indeed added bold new chapters to the history of addiction recovery. And we are here in part to celebrate those achievements.

Our Future Challenges

In thinking about the future of recovery advocacy, I would like to note a few of the challenges we will be facing.

Movement Maturation In addressing the future of our recovery advocacy movement, the first challenge is to weather the growing pains of all maturing social movements, including the challenges of

- programmatic and financial sustainability,
- maintaining a sense of urgency to our efforts,
- managing leadership transitions, and
- preventing cult-like closure, purges, schisms and movement dissipation or implosion.

There are, however, currently three issues that have my attention that I would like to share with you.

Mission Fidelity There has been tremendous growth in recovery support services in the past decade and the risk is that this success becomes the movement. If the recovery advocacy movement is reduced to a peer recovery support industry and if peer recovery support becomes only a loose appendage to addiction treatment, we as a movement will have failed and a future

recovery advocacy movement will need to be rebirthed. We have to make sure that one of our objectives does not become our sole mission.

I think we avoid this by doing two things:

1) balancing our change efforts across personal, family, community, cultural, and global levels. Ideally, we can steward our time and resources across these five areas even when our primary personal or organizational focus is on one of these areas.

2) assertively managing the risks of professionalization and commercialization. We must remain a movement and avoid becoming an industry. We must at all costs avoid undermining the voluntary service ethic that is a hallmark of recovery communities.

Representation Checks Social movements that begin focused on the needs of those most marginalized often abandon these very people as the movement garners success. To avoid that risk, we must continually evaluate:

1) the scope and adequacy of recovery representation—avoiding tokenism,
2) the authenticity of recovery representation (avoid the problem of double agentry in which someone represents themselves as a recovery advocate who is actually representing other persona or /institutional interests), and
3) the diversity of recovery representation.

Backlash Management Every successful movement must survive the backlash it creates. That backlash can spring from many sources. It can spring from:

- our disconnection from those we are pledged to serve,
- those whose interests we threaten—from the alcohol, tobacco and pharmaceutical industries, other AOD-involved organizations (the treatment, criminal justice, and child welfare industries) or from allied professional groups,
- the superficial over-promotion of recovery as a diluted and faddish flavor of the month, or from
- our own excesses and ethical breaches, e.g., highly publicized episodes of emotional/sexual/financial exploitation within the recovery support umbrella.

I suggest two strategies to lower our vulnerability for such backlashes. The first is to always consider our critics as potential benefactors. This requires doing a self-inventory of any element of truth within criticisms we face, regardless of the source or motivation of such criticisms. The second strategy involves the codification and internalization of values and ethical codes that separate healers from hustlers. We must ground our organizations in recovery values and conduct a regular self-inventory of values fidelity. We need ethical standards of practice and structures for selecting, training, and supervising those providing peer-based recovery support services. And our organizations, workers, and volunteers must be held accountable to fidelity with those values and codes of conduct.

A Special Note of Gratitude

Before ending my remarks, we would be remiss in this anniversary celebration if we did not acknowledge the debt of gratitude we owe to recovery leaders within indigenous and communities of color and within the LGBTQ community. These communities have made

numerous contributions to our movement, but I think they have gifted us with two particularly priceless lessons. They have taught us the import of time in their illumination of historical trauma, historical resistance and resilience, the value of elder and ancestor guidance, and the need to weigh each of our decisions on its potential effects for the next seven generations. They have also taught us the importance of space: that recovery requires fertile soil to grow and that we must create those healing forests in which recovery can flourish that Don Coyhis so eloquently describes. Through these perspectives on time and space, these communities have shown us the nexus between recovery advocacy and social justice. We are only beginning to grasp the full implications of these gifts.

And An Opportunity

I would also be remiss if I did not acknowledge that we live in a deeply wounded and suffering country at present. Our communities and our country need a recovery process. As experts on the journey from brokenness to wholeness, we can and should be included among its healers. Where else in America do people of diverse political and religious affiliations and cultural backgrounds speak to one another daily with respect and mutual support than “in the rooms” of recovery? The values our country most needs at this moment are values that have guided our recoveries: unity, honesty, humility, tolerance, respect, gratitude, forgiveness, love, and service. These are the balms we can apply to heal America’s bleeding wounds. There is a larger call to service here that awaits us.

Closing

In closing, I firmly believe we will extend these achievements and face these threats and opportunities. Twenty years ago, our speakers challenged us to return to our communities and make some history. We did precisely that. Members of my generation are nearing the end of our service ministries. It is our hope that your lives will be as fulfilled in this ministry as ours have been. We hope the lessons we have learned will be helpful to you, but circumstances change and sometimes the old lessons are no longer viable. What each generation of recovery activists must do is to show up and figure out how to affect change within their own era and then pass the advocacy torch to the next generation, informed by but not trapped by, the past. In passing this torch to you, we leave the future of recovery in your hands. We wish you Godspeed on your journey into that future.

White, W., Stauffer, B., & Tarino, D. (2021). Personal privacy and public recovery advocacy. Posted at www.williamwhitepapers.com (from a blog series posted November-December 2020).

Personal Privacy and Public Recovery Advocacy

William White, Bill Stauffer, and Danielle Tarino

A central strategy of the new recovery movement is sharing our stories in public and professional venues to change public perceptions and public policies related to addiction and recovery. Drawing from earlier social movements, we learned that "contact strategies"—increasing personal contact between marginalized and mainstream populations—is one of the most effective means of reducing stigma and discrimination and expanding opportunities for full community participation. Public attitudes toward those recovering from alcohol and other drug problems become more positive when members of the public have positive exposure to people living in long-term recovery with whom they can identify.

We also learned that there were limitations to this approach of public recovery storytelling. Changing personal attitudes of those exposed to our stories left in place much of the institutional machinery (e.g., laws, policies, and historical practices) that negatively affected individuals and families experiencing alcohol and other drug problems. Twenty years into the new recovery advocacy movement, discrimination against us remains pervasive. We must remain vigilant to prevent appropriation of our stories by others to support unrelated agendas. When this happens, we experience further marginalization.

People in recovery face discriminatory barriers in housing, employment, education, professional licensure, health care, and numerous arenas of public participation (such as voting and holding public office). Laws and regulations intended to protect us from discrimination remain unenforced. Addiction treatment remains of uneven quality, often lacking in long-term recovery orientation, and limited in its accessibility and affordability. Too many communities lack long-term recovery support services. And people in recovery continue to be excluded from meaningful representation within alcohol and drug and criminal justice policy discussions and decisions.

It is in this context that we must be clear about what our public recovery storytelling can and cannot achieve, and relatedly, who precisely is responsible for eliminating entrenched policies and practices that have such a direct impact on our lives.

There is a paradox within our anti-stigma efforts. We must challenge oppressive barriers to recovery and full participation in community life. As Frederick Douglass so clearly and eloquently stated, "Power concedes nothing without a demand." Historical inertia and personal and institutional self-interests sustain structures of oppression until

they are challenged. Who will pose such a challenge if not people in recovery? Yet the ultimate responsibility for dismantling discriminatory practices rests upon the shoulders of the systems within which such oppressive machinery continues to operate. The responsibility to eliminate discrimination rests with those who discriminate. By itself, telling the perfect recovery story will not end discriminatory practices.

So where does recovery storytelling fit into all this? Our stories are a means of humanizing addiction and recovery—a means of challenging the myths, misconceptions, and caricatures that have let others objectify and isolate us. Our stories are an invitation for people to reconsider the sources of and solutions to alcohol and other drug problems. Our stories are a means of building relationships that embrace us within the human family—as people who share the dreams and aspirations of others. Our stories, directly or indirectly, also constitute Douglass' demand to change the structures that have prevented embrace of our humanity and rendered us people to be feared, shunned, or punished. This involves far more than changing people's perceptions, attitudes, and behaviors toward those with lived experience of addiction and recovery. It involves identifying and eliminating the precise mechanisms (e.g., policies and practices) through which social shunning and discrimination have been institutionalized.

This is not to suggest that people in recovery have no role to play in this change process nor that we should passively embrace a victim status in the face of such systemic challenges. We can take responsibility for our own personal and family recovery, make amends to those we have harmed, and reach out to others still suffering. We can participate in recovery-focused research (to create a science of recovery that can challenge recovery misconceptions), participate in protests and advocacy efforts, offer our recovery stories in public and professional educational venues, and represent our lived experience within policy-making settings. Such actions have contributed to numerous positive changes.

Our stories possess immense power as long as we recognize our stories alone will not create recovery-friendly social institutions or recovery-inclusive communities. We must not allow our stories to stand as superficial window-dressings while discrimination remains pervasive, even among some of the very groups and institutions who on the surface support our storytelling. Our stories must support specific calls for institutional change. We must hold individuals and institutions that discriminate accountable until they eliminate such conditions.

How we craft and communicate our stories for public/professional consumption is an important element of this process of social change. Recovery advocacy organizations have a responsibility to prepare and support the vanguard of individuals who heed the call of this public story-sharing ministry. This includes building a community ethic that protects those who possess the bravery and privilege of sharing their recovery stories in public forums. Collecting our stories without meaningful

dialogue about how our stories will be used and the protections we will be afforded is unacceptable.

This is the first in a continuing series of blogs on personal privacy and public recovery advocacy. We hope it will set recovery storytelling within a larger context. The remaining blogs will explore the risks of public recovery storytelling, the ethics of public recovery story sharing, and suggest guidelines on protecting personal privacy and safety within the context of public recovery storytelling. The impetus for this series comes from our knowledge of individuals who have experienced unanticipated harm related to their advocacy efforts.

The Risks of Public Recovery

Public Recovery Storytelling: Spectrum of Risks

Individuals, family members, organizations, and the recovery advocacy movement reap benefits from public recovery storytelling, but these same parties are also at risk for injury as an inadvertent outcome of such public storytelling.

Individuals and family members may experience the therapeutic effects of their advocacy activities, but there are also accompanying risks of personal embarrassment or humiliation, exposure to acts of social shunning or discrimination, and, at worst, destabilization of personal and family recovery. Moving recovery from the private to public arena entails navigating these risks.

Youth and other individuals at early stages of recovery may be particularly vulnerable for such injuries. The media story of recovery is most often told from the perspective of the recovery initiate rather than from the perspective of long-term recovery. We best represent the story of recovery when we speak from panels representing diverse pathways, styles, and stages of addiction recovery. Young people and others in early recovery possess heightened vulnerability and should be carefully screened for public recovery advocacy activities. They should be oriented to the benefits and risks of public recovery disclosure via an informed consent process and given structure and support when involved in public recovery advocacy. If a person experiences a recurrence of AOD use and related problems who has earlier served as public recovery advocate, their prior experience as a visible recovery advocate can pose a significant obstacle (via shame, resentment, etc.) to recovery restabilization.

> *There is a zone of service and connection to community within advocacy work, and we must do a regular gut check to make sure we remain within that zone and not drift into advocacy as an assertion of ego. The intensity of camera lights, the proffered microphone, and seeing our published words and images can be as intoxicating and destructive as any drug if we allow ourselves to be seduced by them. If we shift our focus from the power of the message to our power as a messenger, we risk, like Icarus of myth, flying towards the sun and our own self-destruction. To avoid that, we have to speak as a community of recovering people and avoid*

becoming recovery celebrities—even on the smallest of stages. (White, 2013)

The decision to pursue public recovery advocacy is best made in consideration of family and loved ones. While the zealous new recovery initiate may feel called to this public storytelling role, they must consider the potential effects of public disclosure on family members and loved ones. After considering such effects, some advocates have postponed their roles as public speakers until their children are at an age that minimizes any potentially negative effects upon them. Those involved in public recovery storytelling have found it helpful to orient family members and loved ones on the content of the story, the venues in which it will be shared, and how to best respond to questions that may arise from its presentation.

The reputations of organizations sponsoring public recovery storytelling and the larger recovery advocacy movement can be injured when speakers are not provided support, guidance, and vetting by the community for suitability and readiness for public recovery story sharing. This is particularly true in the case of the perceived "fall from grace" of a visible recovery advocate. In such circumstances, individuals and families suffering from addiction may be less hopeful and less likely to seek help because of such damaged reputations, and policymakers may be less amenable to supporting recovery advocacy organizations.

Recovery Storytelling: The Risk of Conflicting Agendas

Information related to addiction and recovery is disseminated through a wide variety of public venues: television, film, newspapers, magazines, the Internet, and through a broad spectrum of public and professional meetings. Representatives from these venues often approach recovery advocates for interviews or presentations related to their recovery experiences. Such opportunities are a means of carrying a message of hope to those affected by alcohol and other drug problems and a platform for advocating pro-recovery social policies and programs.

In spite of the potential benefits of public recovery storytelling, public recovery disclosure as we have noted can pose risks to multiple parties. A starting point for risk management related to public recovery story-sharing is the recognition that the interests of the multiple parties involved in such events may be congruent or in conflict. Requests for interviews or presentations often come with hidden agendas—planned narratives that meet the interests of those doing the inviting. Those inviting our stories may distort them to support agendas and talking points incongruent with the goals of recovery advocacy.

For example, distorted media coverage of active addiction fuels social stigma and contributes to the discrimination that many people in recovery face as they enter the recovery process. When media representatives interview people in recovery, they often want the most dramatic, traumatic, and sensationalist details related to one's

addiction but seek or report few details on the actual processes of recovery or the regenerative and transformative effects of long-term personal and family recovery.

It is said that if you are not at the table, you are on the menu. This has never been any truer than with the use of our stories. We must have pointed dialogue about how our narratives are used while having meaningful discussions across our diverse community on the messages we are trying to convey. These discussions must include how our stories can have unintended consequences and we must work together to ensure that our stories serve our common interests and our shared vision of an inclusive world free from stigma and discrimination.

This is all a way of saying there is much to consider in the decision to share our story, our decisions on how that story can be best presented to different audiences, and how we can best protect ourselves and other parties through this process.

Pillars of Stigma and Recovery Storytelling, stigma

A central goal of public recovery self-disclosure is to challenge myths and misconceptions about addiction and recovery through the elements of our personal stories. Recovery advocates must avoid contributing to false narratives by having selective parts of our stories appropriated while ignoring the central recovery message.

Addiction/treatment/recovery-related social stigma and its untoward consequences rests on old and new misconceptions regarding the sources and solutions to alcohol and other drug problems. Such key pillars of belief about the nature of addiction, addiction treatment, and addiction recovery constitute the structural supports of addiction-related social stigma. Below are examples of such pillars (in the stigmatized language in which they have been historically conveyed) and how our stories can be hijacked to support these false narratives.

<u>Addiction is a product of moral turpitude (badness)</u> that is best prevented and discouraged by public shaming and other forms of punishment. Acts flowing from this premise began with American colonies forcing those convicted of public intoxication to wear the letter D (for “Drunkard”) on their clothing or to be set in stock in the town square under a sign reading “drunkard.” The moral turpitude pillar continues to feed social shunning, serves as grounds for divorce, and provides a rationale for political disenfranchisement and discrimination in housing, employment, education, and medical benefits. Overemphasizing or exaggerating the “bad people” we were in the addiction portion of our stories inadvertently feeds this view.

<u>Addicts pass on their degeneracy (“bad seed”) to their children</u>. This pillar of belief has resulted in the inclusion of addicted people in mandatory sterilization laws, surgical sterilization without consent during institutionalization, and loss of parental custody and related legal rights. It also feeds false narratives that paint the children of addicted parents with the same brush, e.g., false narratives of “crack babies” as a “biological underclass.”

The addict is an infectious agent who must be closely surveilled and isolated from the community. This pillar of belief provided the rationale for inebriate penal colonies, prolonged institutionalization in psychiatric asylums, prolonged surveillance (addict registries, prolonged probation/parole), and fed the modern era of mass incarceration.

Addicts pose the greatest threat to the community when they associate with each other. This belief undergirded laws banning addict fraternization and probation or parole violations for associating with other addicts. “Loitering addict” laws provided for the arrest of known addicts for simply being in the presence of other individuals identified as addicts. Policies that dissuade recovery networking and the inclusion of recovery voices in matters that affect us may well be rooted in earlier biases against addicts being with each other.

Addiction does not discriminate. Actually, it does! It was with the purest of intentions that the tagline of "addiction does not discriminate" became one of the public education mantras in the wake of the "opioid epidemic." It was a way of saying, "See...it could happen to anyone... and now you should care." This narrative sought to normalize (AKA Whiten) addiction by projecting the image of “innocent,” (AKA White), middle-class children and their parents deserving of public resources to support their care. Such care was advocated as an alternative to arrest and incarceration for the “deserving” (AKA White people of means), while addiction in communities of color continued to be stigmatized, de-medicalized, and criminalized.

Stating that alcohol and other drug problems cross boundaries of race and class in the United States obscures the inordinate toll addiction and drug policies have long taken and continues to take on communities of color and other historically marginalized populations. The addiction vulnerability of these communities stems from historical trauma; social, economic, and political marginalization; and related disparities in access to prevention, harm reduction, early intervention, treatment, and recovery support services. An ethical framework of public messaging and education would call for equity of policy application and resource allocation across all affected communities. Ideally, recovery storytelling would include the stories of people from diverse backgrounds and living circumstances. It is important that through our stories we convey the reality of recovery, the varieties of recovery experience, and the challenges of recovery across cultural contexts.

Addiction is untreatable (“Once a junkie, always a junkie.”) This pillar of belief feeds personal, public, and professional pessimism about addiction and provides the rational for prolonged institutionalization/incarceration as well as justification for harmful and potentially lethal treatment experiments. In the U.S., the latter have included brain surgeries, indiscriminate use of chemo- and electroconvulsive therapies, toxic drug withdrawal procedures, and other harmful treatment methods. Portraying the role treatment played within our recovery stories and the nature and positive effects of modern treatment challenges this misconception.

Treatment Works! is a counter misconception in that it suggests the presence of a uniform protocol of addiction treatment in the U.S. that achieves consistently positive clinical outcomes. It also ignores widespread addiction treatments that lack empirical evidence of their effectiveness as well as the presence of treatments more focused on financial profit than long-term recovery outcomes. This central marketing slogan of the treatment industry misrepresents the highly variable outcomes of addiction treatment, which span minimal, moderate, and optimal effects, as well as harmful effects. Addiction is a treatable condition, but recovery outcomes depend upon numerous personal, clinical, and environmental factors. Great care must be taken in how our stories are used by the addiction treatment industry. What we are offering as advocates is living proof of long-term recovery, not an advertisement for a particular proprietary approach to addiction treatment. (See HERE for full critique of this slogan.)

Recovery is not possible until an addicted individual "hits bottom." Actually, most people recover from addiction long before hitting bottom" (losing everything). Addiction-related loss and pain in the absence of hope is an invitation for continued self-destruction. Recovery initiation is the fruit of addiction-related consequences interacting with sources of hope for a healthier and more meaningful life. The "hit bottom" premise suggests that recovery responsibility rests solely with the individual—that there is little family or community can do until that point of individual awakening arrives. This constitutes an invitation for family and community abandonment of those suffering from addiction. This premise is untrue, is not applied to other medical conditions, and should be forever discarded within the addictions arena. We must not let our story be twisted to support this supposition even if we were one of those who did hit bottom and lost everything.

Addiction recovery is the exception to the rule. Actually, recovery is the norm; individuals who do not achieve sustainable recovery are the exceptions. Those who struggle with recovery stability are distinguished by higher problem severity, co-occurring problems that make recovery initiation and recovery more difficult, and fewer natural recovery supports in the community. Even people with the most severe addiction problems can and do recover with more intense and prolonged recovery support resources. We must repel any effort to cast our recovery as the heroic "exception to the rule" and convey the consistent message that no one need die of addiction. Recovery is far more than possible; it is the probable long-term outcome for those who experience alcohol- and other drug-related problems.

Addiction recovery is a brief episode that allows one to then get on with their life. For people with mild to moderate levels of addiction severity who possess substantial recovery capital, recovery may be just that. However, for those escaping addictions marked by severity, complexity, and chronicity, recovery is a prolonged process comparable to the assertive and sustained management needed for other chronic medical conditions. It is important in our stories to acknowledge variability of addiction

severity and recovery support resources. Our recovery story is just that—our personal story; it is not the whole addiction/recovery story.

Media channels frequently tell the story of addiction recovery only as a personal story rather than a larger story of the role of family and community in addiction and recovery. The prevalence and severity of addiction are profoundly influenced by social, economic, and political contexts. The recovery tipping point has as much to do with family and community resources and capacity for resource mobilization as it does what is going on inside the addicted person. We serve best when we present our journey from addiction to recovery within these larger contexts and extoll the role of family and community in the recovery process.

Addiction recovery is only achieved through a particular type of professional treatment, lifelong affiliation with a recovery mutual aid society, and lifelong abstinence from alcohol and illicit drugs. Actually, people recover from substance use disorders with, and without, treatment, and through diverse approaches to treatment and recovery support. People achieve recovery with and without involvement in recovery mutual aid groups. Professional- and peer-supported pathways of recovery constitute particular styles of recovery, not the only pathways to recovery. Those involved in treatment and recovery mutual aid represent more severe and prolonged patterns of addiction. There are secular, spiritual, and religious pathways to alcohol and other drug (AOD) problem resolution, and AOD problems can be resolved through styles of sustained abstinence or through decelerated patterns of drug use (the latter most viable for individuals with less severe AOD problems and greater social supports). Our personal story illustrates one within many pathways and styles through which people resolve AOD problems. We preface our stories with “In my experience…” and “What I have observed is…” We are sharing our experiential knowledge, not universal truths that have stood the tests of science or application across diverse cultural contexts.

The above pillars of belief (and the degrading caricatures that often accompany them) serve the interests of multiple parties. They aim to socially stigmatize and discourage drug use. They disparage groups with whom the drug is, correctly or incorrectly, associated. They justify surveillance and over-policing of marginalized communities. And they feed institutional profit. Collectively, these pillars define us as a people as outsiders--outcasts for whom doors of entry into the human community should remain closed.

Our goals run counter to these interests. Our intent is to elicit what Isabel Wilkerson has christened “radical empathy”—the ability of listeners to emotionally project themselves into our experience to the point that they move beyond tolerance and compassion to actions that include us within the human community. This requires framing our stories to elicit conscious awareness that addiction is only one of many forms of woundedness that can and do touch all of our lives, and that recovery mirrors the promise of healing that can follow. The challenge we face is to assure that our

recovery stories serve this higher purpose and not feed false narratives that are part of the problem.

The Ethics of Public Recovery Self-disclosure

Ethics involves the application of moral principles to promote good and prevent harm. Ethical decision-making within our service and advocacy activities is an assessment of the ratio of potential benefits to potential harms in any course of action—with a particular emphasis on “first do no harm.”

Such decision-making involves asking ourselves three questions. First, what parties could benefit or experience harm in this situation (and what is the degree and duration of such benefit or harm)? In our advocacy roles, it is helpful to assess such potential benefits and harms related to ourselves, our families, organizations with whom we are associated, the recovery advocacy movement, and the community.

Second, are there any laws, policies, or historical practices that offer guidance in this situation? This question illuminates the complexities between law and ethics: actions may be legal and ethical, unethical and illegal, legal but unethical, or illegal but ethical.

Third, what ethical values are most applicable to this situation and what course of action would these values suggest? Self-disclosure as an ethical issue has been explored in both professional and peer recovery support contexts (See HERE and HERE), but little attention has been focused on ethical concerns related to self-disclosure within the context of public recovery advocacy. Several traditional ethical values inform decisions related to disclosure of our personal recovery stories in public or professional settings.

Beneficence is the ethical command to help others and not exploit the service context. It invites us to share our story as a means of helping individuals and families suffering from addiction and commands us to focus that story on those in need rather than as an act of self-aggrandizement or a means of pursuing our own interests.

> *Nonmaleficence* is the ethical command to do no harm. In the context of public recovery storytelling, it forces us to assess the timing and the intended and unintended consequences of our public disclosures on ourselves and other parties.
>
> *Honesty* demands that the recovery story be a truthful representation of our experience. Honesty and candor challenge us as advocates to speak truth to power even when lacking confidence in the authority of our own voice.
>
> *Fidelity* calls upon us to keep our promises. It asks us to remain faithful to pledges we have made to individuals and organizations. It asks us not to

make promise that we cannot keep and to adhere to commitments made in the context of our story sharing.

Justice requires that we acknowledge disparities in recovery opportunities and resources and calls on us to seek equity in such opportunities and resources.

Discretion calls upon us to protect our own privacy, the privacy of our family, and the privacy of others in the presentation of our story. Public recovery storytelling is an act of public service; it is not public therapy or a platform for airing personal grievances.

Self-protection calls upon us in our service roles to avoid harm to self, family, and others. It is an acknowledgment of the legitimacy of tending to our own safety and health. It is a recognition that risks of harm to self and others exist within the public storytelling arena.

There are also values deeply imbedded within the history of communities of recovery that can inform recovery storytelling within public and professional arenas.

Humility reminds us of the dangers of ego-inflation and that we speak not for ourselves but for the experiences and needs of all people seeking and in recovery. (See earlier blog on distinction between recovery rock stars and recovery custodians)

Gratitude is a call to give credit where it is due and to express our thanks to individuals and organizations that made our story possible. We offer our own story in thanks for the meaning we drew from the stories of others at a time we were most desperate of the hope they offered.

Respect/Tolerance is a recognition of the spirituality of imperfection—that we are all wounded in some way, that through this shared brokenness and healing, we share a profound connectedness. It is an extension of humility and empathy—seeing ourselves in the lives of others and respecting multiple pathways and styles of recovery.

Service is the call to carry a message of recovery to all those who continue to suffer from addiction and related problems. We do that as an act of altruism and as a perpetual step in our own self-healing.

There are many decisions involved in public recovery storytelling. Filtering these decisions through a model of ethical decision-making and core values of recovery can help minimize risk to self and other parties.

Guidelines for Personal Safety and Public Recovery Self-disclosure

He who shows himself at every place will someday look for a place to hide. –African Proverb

The Decision to Disclose

Before disclosing our recovery status or details of our addiction/recovery experiences at a public level, we suggest giving careful thought to such questions as:

- Is this the right time in my recovery to share my recovery story at a public level? Will this strengthen my recovery or would it be a diversion from more critically needed recovery activities?

- Are there any negative effects for myself, my family, my community, and organizations within whom I am associated that could result from sharing my story in public or professional settings?

- Could such story sharing subject me to discrimination in housing, education, employment, health care, or social and business opportunities? Could it have any legal ramifications?

- Do I have a support system that could help me manage any such effects if they should arise?

- Will I be sharing my story alone or alongside other people in recovery?

- Do the potential benefits of public disclosure as a community service outweigh the potential personal risks?

- Who is controlling how my disclosure will be used and is there an explicit right for me to have the final edit on what elements of my disclosure are presented?

Purpose of Public Disclosure

Many people in recovery will have shared their recovery story with family and friends, with medical and treatment professionals, and with other people in recovery before the opportunity for public recovery disclosure arises. Public disclosure is different from any of these preceding situations and involves a different purpose and style of storytelling.

Public recovery storytelling is about service to a larger cause than self. It is the use of self and one's own story as a catalyst for personal and social change. With each story sharing opportunity, we prepare ourselves by asking key questions. What do I want members of this audience to understand, feel, and do? How can I present my story in a way that will achieve those goals? How can what I do today contribute to the larger goals of the recovery advocacy movement?

It is important that addiction treatment and recovery community organizations provide a process of informed consent when inviting individuals to share their stories in public and

professional contexts. This involves a clear statement of the potential benefits and risks of public disclosure and screening out individuals for whom such disclosures present an unacceptable level of risk. Asking individuals currently receiving services to participate in public story sharing or marketing activities is coercive and exploitive.

Disclosure Preparation

Many of the risks involved in public recovery story sharing can be avoided with adequate orientation and training. Messaging training has been an effective tool used by Faces and Voices of Recovery and other recovery advocacy organizations to prepare people for this unique service ministry. Messaging training spans both the intent and content of public story sharing and the mechanics of effective story sharing (e.g., language, tone, adaptation for different cultural contexts and audiences, etc.). Pursuing these activities within an established recovery community organization helps assure peer and supervisory support for the “ups and downs” of such sharing experiences.

Public Self-disclosure and 12-Step Anonymity

AA, the precursor of all 12-Step programs, promulgated a tradition of personal anonymity at the level of press as both a protective device for AA and as a spiritual principle. Public disclosure of recovery status and sharing one’s recovery story without reference to affiliation with a particular 12-Step program complies with the letter of 12-Step traditions (See Advocacy with Anonymity), but it may not always meet the spirit of the Traditions. This could occur when advocacy is used as a stage for assertion of self (flowing from ego / narcissism / pride and the desire for personal recognition) rather than as a platform for acts of service flowing from remorse, gratitude, humility, and a commitment to service. For members of 12-Step fellowships, adhering to anonymity traditions (in letter AND spirit) in public recovery story sharing is recommended as a protection both for 12-Step programs and for the protection of the recovery advocate.

Timing of Disclosure

Our capacities (energy, abilities, competing needs and demands) for recovery advocacy ebb and flow over time. It is appropriate to ask ourselves if this is the optimal time for public recovery story sharing, whether this is the first time we have such opportunity or whether we need to take a break from such activities during times of personal distress or competing demands that require our focused attention. Warning signs indicating the latter include losing emotional control over the content of our story sharing (via unplanned expressions of frustration, resentment, anger, sorrow) or experiencing boredom or a loss of energy in our public story sharing. Difficult experiences and emotions can be referenced strategically within our talks (once we have emotional control over them), but public and professional meetings are not the appropriate venues to work out unresolved traumas of the past or present. When we drift across that line, it is time to take a break from this public service role.

Scope and Focus of Disclosure

People in addiction recovery have many stories they can share. There is the life preceding the onset of drug use, one's addiction career, the turning point of recovery initiation, and the story of one's personal and family life in and beyond recovery. All of these may be touched on in public recovery story sharing, but the emphasis of this story must be on the recovery story and the lessons drawn from it. Great care is required with the media to maintain this focus. There are dangers that others hijack a recovery story intended to lower stigma in a way that fuels stigma, social marginalization, and the criminalization of addiction. We best serve the advocacy movement and protect ourselves by maintaining a focus on the recovery side of our stories and how we escaped the chaos and drama of addiction.

Depth of Disclosure

There exists a continuum of intimacy defining the degree of risk in public recovery story sharing. There are experiences, feelings, and thoughts known only to ourselves that we have not shared with anyone else. There are experiences, feelings, and thoughts we have shared with only within our most trusted relationships. There are the communications we have expressed only within the context of professional counseling, within a sponsorship relationship, or recovery mutual aid meetings. And there are things about ourselves we have shared widely with those we encounter in our daily lives. Such communications range from high emotional risk to low emotional risk. The question is: Where does sharing our recovery story in professional or public meetings, in media interviews, or on social media fit in this continuum?

All recovery story sharing at a public level involves potential risks to ourselves and other parties, but those risks increase in tandem with the level of detail about our experiences contained within those stories. The category "people in recovery" includes highly armored people who are unable to trust others enough to share their real experiences, feelings, and thoughts. Others in this category enter recovery with no armor and no boundaries to facilitate the nuances of self-disclosure and self-protection in different settings and relationships. People existing on the extremes of this continuum from overly guarded to completely unguarded may need greater time in recovery prior to recovery story sharing at a public level. All people on this continuum need guidance and discipline to manage the depth of public recovery disclosure and the discipline to maintain this boundary over time.

Training and supervision related to public recovery disclosure can provide a safe setting in which we can address such questions as the following:

- What is the level of risks (who could experience harm and to what degree?) in the following story sharing venues: a social media post; a radio, television or newspaper interview; speaking at a recovery celebration event; speaking to a professional audience; or speaking to a public audience; writing an article or memoir about our recovery experience?

- What parts of my story are not appropriate to share publicly? (We want to break no-talk rules related to addiction/recovery, but we want to avoid disclosures that are so intimate in detail that they pose threats to our own emotional health or repel those who hear our story.)

- What aspects of my past or present experience remain too emotionally intense to include in my public recovery story? (These are the boundaries we need to define BEFORE we stand before an audience or sit for an interview! Message training and peer supervision can assist this process.)

- Have I avoided referencing other people's stories who might experience harm or discomfort resulting from my disclosure? (It is best to get permission for inclusion of others within our stories, e.g., spouse, family members.)

- Have I fully explored why I am sharing my story and sought feedback from other people who know me to understand the nuances and potential unintended consequences of disclosure?

Facing Criticism of Public Disclosure

As a final note, it is not unusual for individuals disclosing their recovery story at a public level to draw criticism for such activities from expected and unexpected quarters. You may be accused of "grandstanding," "ripping off the program," violating program traditions," or be caught in the crossfires of various ideological debates. Some will comment on what you should have or shouldn't have included in what you shared. Our advice is to have one or more people you are close to who can help you sort such feedback. And to positively use what you can and disregard the rest. Do know that such criticism is inevitable and can help us refine our message and its delivery—even when the criticism is unfounded and prompted by spurious motives.

Closing

We have tried in this paper to explore the purpose, contexts, and risks of sharing our recovery stories at a public level and to explore some of the ethical issues involved in recovery story sharing. It is our hope that these discussions and suggested guidelines will serve as a catalyst for discussion and a tool for the training of recovery advocates who choose to join the vanguard of people who are putting a face and voice to the recovery experience.

Our stories have the power to achieve many things, but we must not embrace total responsibility for eliminating addiction/recovery-related stigma. Those individuals and institutions who spawned and perpetuated stigma and discrimination bear that responsibility. What we can do is offer our stories and our larger advocacy activities to offer hope to wounded individuals, families, and communities and do so in a way that protects our own health and safety.

Reflections on the historic 2001 Recovery Summit in St. Paul, Minnesota, and the start of the New Recovery Advocacy Movement Article One – The Thoughts of Recovery Historian Bill White

Stauffer, B. (2021). Recovery Review: Reflections on the historic 2001 Recovery Summit in St. Paul, Minnesota, and the start of the New Recovery Advocacy Movement Article One – The Thoughts of Recovery Historian Bill White. Posted at https://recoveryreview.blog/2021/04/10/reflections-on-the-historic-2001-recovery-summit-in-st-paul-minnesota-and-the-start-of-the-new-recovery-advocacy-movement-article-one-the-thoughts-of-recovery-historian-bill-white/

APRIL 10, 2021 ~ BILL STAUFFER PA

Background: History is incredibly important to how we understand ourselves, where we came from, where we stand now and to assist us in determining our pathways forward. Few things are more important to me than understanding the New Recovery Advocacy Movement and to support efforts to move us towards an expanded recovery community across America. As addiction is arguably our most profound public health challenge, recovery in all its diversity offers the greatest hope of restoration at the individual, family and community level.

This year marks the twentieth anniversary of the historic 2001 Recovery Summit in St. Paul Minnesota. I felt that one of the most important contributions I could do would be to collect some of the recollections and thoughts of recovery leaders who were present at this historic event. I have developed a series of questions I hope to ask as many attendees as I can locate over the course of the coming months. My goal is to document their recollections on what the summit meant to them, the accomplishments of the new recovery advocacy movement that rose out of this historic summit and thoughts for the future.

Bill White, the widely regarded recovery movement historian, writer, researcher, streetworker, counselor and elder stateman of recovery who started working in it in 1969 has generously agreed to be my first respondent. I am deeply grateful to Bill for his life work on addiction and recovery and for his willingness to mentor and support so many of us across this movement nationally, myself included.

Questions to Bill White and his responses:

Who are you and what brought you to St Paul at that time?

I am a person in long-term addiction recovery who has worked in the addictions field for more than 50 years in such roles as outreach, counseling, clinical supervision, recovery research, and teaching. I have also spent most of those years researching and writing

about the history of addiction treatment and recovery in the United States. I am currently Emeritus Senior Research Consultant at Chestnut Health Systems.

By the late 1990s, I was convinced the addictions field needed to shift its central organizing framework from a focus on addiction pathologies and brief clinical interventions to a focus on the prevalence, pathways, styles and stages of long-term personal and family recovery. I also was advocating the extension of brief clinical models of treatment to a model of sustained recovery management nested within a larger recovery-oriented system of care. As a recovery historian, I had begun to document the rise of new and renewed grassroots recovery community organizations (RCOs) and what I was labeling a "new recovery advocacy movement." In 2000, I began writing papers on this emerging movement, drawing on my experience working with these new RCOs and my consultations and presentations to those RCOs funded under CSAT's newly developed Recovery Community Support Program (RCSP). At this time, I was also serving on the Board of Recovery Communities United in Chicago, one of the RCSP grantees.

In early 2001, I was asked by William Cope Moyers (Johnson Institute) and Jeff Blodgett (Johnson Institute's Recovery Alliance project) to participate in a planning meeting to explore the possibility of a national recovery summit that culminated in the St. Paul Recovery Summit in October 0f 2001.

Is there a particular moment or memory that stands out to you from that summit?

I have vivid recollections of the wonderful presentations and the working sessions at the Summit, but those are not what most stand out for me. What mattered was that we were there together as "people in recovery"—an identity that transcended all other identities and boundaries. At that meeting, we became "a people" apart from our affiliation or lack of affiliation with any particular recovery mutual aid group or any other personal or professional identities we might claim. By the time I arrived in St. Paul in 2001, I had been in thousands of meetings without ever sensing that any of those events were history making. The Recovery Summit in St. Paul was different. There was electricity in the air from the moment we gathered and I distinctly remember thinking at one point that what we were doing could mark a new chapter in the history of addiction recovery—a line in time between that in the future would demarcate "before" and "after." You see, many of us knew of each other but we had never gathered as recovery advocates. The energy generated by finally placing so many of us in one place was amazing. That energy and its resulting shared vision is what I most remember.

What did you see as the motivating factors that brought you all together for that historic summit twenty years ago?

The historical context was important. There was awareness of the failure of earlier organizational efforts such as the Society for Americans in Recovery (SOAR) and calls for extending the historical work of the National Council on Alcoholism and Drug Dependence (NCADD). The Summit was in many ways a call to take recovery

advocacy into the 21st century. We had lived through the demedicalization, restigmatization and intensified criminalization of addiction in the 1980s and 1990s that resulted in the mass incarceration of addicted people. The Summit was a backlash against such practices led by people who offered living proof of an alternative. New grassroots and renewed RCOs were popping up around the country. The summit was an acknowledgement of their existence and an expression of their aspirations. Since 1998, The Center for Substance Abuse Treatment (CSAT) had provided seed money to a small cadre of RCOs via its Recovery Community Support Program (RCSP). The Summit was a way of extending that effort far beyond those few CSAT-funded funded RCOs. In some ways, the Summit was also a protest against the addiction treatment industry—the sense that people with severe, complex, and long-standing addictions were being recycled through brief episodes of care for financial profit of treatment organizations without regard to their need for long-term personal and family recovery support. Many of us had reaped the benefits of treatment, but we were also painfully aware of its limitations and the need for more vibrant and recovery-focused models of care. There were also groups like White Bison and the Recovery Association Project that were calling for us to move beyond clinical models of care to models of community organization and cultural revitalization. All of these influences stirred within the pot of the 2001 Recovery Summit.

How have we done in accomplishing those early goals? What do you see our greatest successes to date are?

What we have witnessed in the 20 years since the St. Paul meeting is in many ways far beyond what we could have dreamed of at that time.

We have witnessed the international growth and diversification of secular, spiritual, and religious recovery mutual aid groups as well as innumerable special needs support groups.

We have witnessed the cultural and political mobilization of people in recovery and their allies at a level that would have been unthinkable in 2001. And we are doing this in diverse cultural communities—far beyond that found in earlier recovery advocacy efforts. That we would have so many RCOs in the U.S. and that we would witness tens of thousands of people in recovery marching in public recovery celebration events was beyond what we could have thought possible during our deliberations in St. Paul.

We have launched major anti-stigma campaigns, including interrogating and challenged the language and images through which AOD problems have been historically expressed. These campaigns have normalized addiction recovery and broadened the pathways of entry into recovery in communities across the country. Early kinetic ideas within the recovery advocacy movement have garnered wide cultural and professional acceptance, e.g., “Recovery is a reality for individuals, families and communities,” “There are multiple pathways of recovery and ALL are cause for celebration,” “Recovery flourishes in supportive communities,” etc.

We have seen a dramatic expansion in new recovery support institutions: recovery community centers, recovery residences, recovery high schools and collegiate recovery programs, recovery-friendly workplaces, recovery ministries, recovery cafes, recovery-focused sports and adventure venues, recovery-focused art and music festivals, and on and on. This is recovery community building at its finest. We had only a glimmer of that in 2001. The recovery advocacy movement has been the engine driving such institution building—a critical step for any sustainable social movement.

We have witnessed a dramatic increase in recovery representation with alcohol- and drug-related policy venues and the parallel emergence of recovery as a new organizing paradigm within the alcohol and drug problems arena. That we would have authentic recovery representation at the highest levels of state and federal drug policy was only a dream in 2001. Today, we are closer to that dream than ever before.

We have witnessed substantial work in extending acute care (AC) models of addiction treatment to models of sustained recovery management (RM) nested within recovery-oriented systems of care (ROSC), with a particular emphasis on precovery outreach and post-treatment recovery support checkups and support. Peer-recovery support services provided across the stages of recovery mark a new conceptualization of the traditional addiction treatment continuum of care.

We are today witnessing efforts to integrate primary prevention, harm reduction, early intervention, primary treatment, and long-term recovery support services. We are now placing recovering peers in hospitals emergency rooms and other settings where addicted people experience their greatest vulnerability for harm.

We have helped through our advocacy efforts to expand recovery research funding through NIH, inspired a vanguard of research scientists to focus their careers on recovery research, and supported the work of such new institutions as Harvard's Recovery Research Institute.

I believe all of the above rest on the vision and strategies emerging from the 2001 Recovery Summit in St. Paul. These are all things I did not think I could witness in my lifetime.

What did we miss if anything looking back at those goals?

The original vision was pretty bold and comprehensive but there were areas of shifting emphasis in the years that followed as the movement matured. I think the most important of these was more fully embracing affected families within leadership roles within the movement, more intensified efforts to extend recovery advocacy within communities of color, and a greater emphasis on environmental strategies of recovery support. The latter was helped by exploration of such concepts as recovery capital, community recovery, and recovery contagion as well as through efforts to inject a recovery orientation within prevention and harm reduction services.

What are you most concerned about in respect to the future?

When a social movement articulates many goals, there is always a danger that one goal comes to dominate the whole movement. I am concerned that the rapid growth of funding for peer recovery support services could obscure and minimize our work in other areas, particularly recovery advocacy. And, of course, there are always the dangers of professionalization and commercialization of social movements as well as the danger that such movements can be hijacked by more powerful forces in their operating environment. When a movement achieves success, there are efforts to expand (dilute) its boundaries to serve other interests. We see this with the ever-expanding definition of recovery, and with treatment and other traditional organizations competing for funds devoted to peer recovery support services. During rapid expansion, there is always the risk of bad actors exploiting the movement for their own ends with the movement being then harmed by unethical and criminal conduct. Funding availability within emerging social arenas in which there is little regulatory oversight or lack of a strong ethical foundation is a psychopath's dream. I still worry about the influence of the treatment industry on recovery advocacy. If we simply regress to the marketing arm of the addiction treatment industry or become a superficial appendage providing post-treatment recovery support, the new recovery advocacy movement will have failed and new advocacy efforts will be needed in the future. And of course, we always have the challenges of organizational sustainability, leadership development, and leadership succession. These are normal risks shared by all social movements.

What would you say to future generations of recovery advocates about what we did and what to be cautious of / your wishes for them moving forward?

I want them to know that those of us at the 2001 Recovery Summit were there to accept a torch passed to us from recovery advocates of earlier decades. We have tried to faithfully carry that mission forward and now place it in the hands of new generations. I want them to respect what their recovery ancestors have done without being bound by that history. I also want them to remember that recovery advocacy is not a program of personal recovery and that history is strewn with the bodies of those who thought otherwise. This work cannot be done without a foundation of care for self and care for those closest to us: We cannot carry light into the community while our own home is shadowed in darkness. We must continue to assert the primacy of personal recovery as the foundation for recovery advocacy. We set out in 2001 to change the world and in a real sense we have achieved that and in doing so experienced meaning and purpose in our own lives. We could not do more than wish recovery advocates of the future the same.



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: Godley, M.D., Passetti, L.L., Hunter, B. D., Greene, A.R. & White, W.L. (2019). A randomized trial of volunteer recovery support for adolescents (VRSA) following residential treatment discharge. *Journal of Substance Abuse Treatment*, 98, 15-25. https://doi.org/10.1016/j.jsat.2018.11.014 (doi: 10.1016/j.jsat.2018.11.014) Posted at **www.williamwhitepapers.com**

A Randomized Trial of Volunteer Recovery Support for Adolescents (VRSA) following Residential Treatment Discharge.

Conclusion

"Barriers for treatment providers to offer extended continuing care include:

(a) lack of payor coverage for continuing care;

(b) shortage of clinical time due to large caseloads;

(c) difficulty maintaining adolescent attendance at community clinics over an extended period of time; and

(d) distance and transportation issues, especially for youth from rural and small urban communities (Flynn & Brown, 2016; Godley & Godley, 2011).

Although VRSA requires commitment of resources to cover costs for a project manager to recruit, train, and supervise volunteers, remaining support costs are minimal. Providers may also consider developing decision rules for transferring youth to VRSA in order to decrease large caseloads and create more time for counselors to respond to new referrals. AOD remission at 12months was similar to the more intensive and expensive assertive continuing care (Godley etal.,2014), supporting the possibility that the present study may offer a cost-effective alternative for the field. Future research is needed to expand the range of youth who achieve high recovery support session completion rates, assess the effect of increasing recovery support call duration, and to test VRSA with outpatient youth."



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. (2024). Frontiers of Recovery Research. Keynote Address, Consortium on Addiction Recovery Science (CoARS), National Institute on Drug Abuse (NIDA), April 24-25, 2024
Posted at https://www.chestnut.org/william-white-papers/

Frontiers of Recovery Research

William L. White
Emeritus Senior Research Consultant
Chestnut Health Systems
bwhite@chestnut.org

Good morning, I am humbled by the opportunity to offer some brief reflections on the future of addiction recovery research. I will use this time to explore some of the critical "why, what, and how" questions related to the emerging specialty of recovery research.

Why

First is the question of why an explicitly defined recovery research agenda is needed. Four primary arenas of knowledge, or ways of knowing, exist within the alcohol and other drug problems (AOD) arena: 1) experiential knowledge, 2) common or public knowledge—popular folklore or myth, 3) professional/clinical knowledge, and 4) scientific knowledge. Whole libraries could be filled across these domains with what has been published on addiction and its related pathologies and brief clinical interventions, but until recently, only a few shelves would suffice for what is known from the standpoint of science about the prevalence, pathways, processes, styles, and stages of long-term personal and family recovery.

At the turn of the 21st century, people in recovery and their allies launched a new recovery advocacy movement. They proposed shifting the center of the AOD problems arena from pathology and brief intervention paradigms to a resilience and recovery paradigm. Recovery advocates championed the reality of recovery and challenged the professional/scientific community to measure its population prevalence. They affirmed the existence of multiple pathways of recovery and challenged scientists to map such pathways. They argued that recovery is as dependent on previously dormant internal and external assets as on personal vulnerabilities and pleaded with the professional and scientific communities to extend their focus from pathology assessment to the assessment of personal, family, and community recovery capital. They lamented that some of the most critical questions related to long-term recovery had yet to be addressed by the research community and pleaded with us to address such questions.

We are here in great part to affirm the legitimacy and importance of those requests and to celebrate the early fruits of the resulting work. The shift to a recovery paradigm, and within that shift pursuit of a recovery research agenda, is filled with unmarked hazards and opportunities. Such

a shift requires exploration of some of the most controversial and contentious issues within the alcohol and other drug problems field, with outcomes profoundly affecting individuals, families, organizations, and communities. Thus, the need for venues like our gathering today to carefully weigh the possibilities and pitfalls on our journey toward a science of addiction recovery.

What

The second foundational issue involves the most critical questions that need to be addressed within a recovery research agenda. I will briefly note twelve critical dimensions of recovery that warrant our focused attention.

1. *Definition and Measurement of Recovery* Recent controversies over the proper definition of recovery underscore its import to multiple stakeholders. No science of addiction recovery is possible without a working definition that meets the criteria of precision, inclusiveness, exclusiveness, measurability, acceptability, and simplicity. Comparing research findings across studies is only possible and productive with a shared definition of recovery and common elements of measurement. The implications of such a definition extends far beyond the scientific community to who is married or divorced, who retains or loses custody of their children, who goes to jail or is freed, who is hired or fired, who is approved or disapproved for a loan, who is accepted or rejected for college admission, who is deemed worthy or unworthy as a friend, and so forth. Recovery definitions and measures that serve our research agenda must move beyond vague, aspirational language to achieve the clarity and precision that its import demands.

2. *Neurobiology of Long-term Recovery* Tremendous progress has been made in recent decades in unraveling the neurobiology of addiction, while far less attention has been devoted to unraveling and disseminating information on the neurobiology of short- and long-term addiction recovery. People seeking and in recovery and their caregivers need normative data on the degree and stages of neurobiological repair following recovery initiation, and caregivers need science-informed guidelines on how to best provide stage-specific recovery support. Pathology-focused scientific findings that elicit despair and professional/public passivity are distorting and counterproductive if they do not include recent research findings on brain resilience and recovery that inspire hope and recovery aspirations.

3. *Incidence and Prevalence of Recovery* As a field, we meticulously measure year-to-year trends in the incidence and prevalence of drug use and the toll of addiction via death, disease, and multiple social cost categories, but have, until recently, remained clueless on parallel trends on the incidence and prevalence of recovery. Recent recovery prevalence and life in recovery surveys are challenging many prevailing myths about addiction recovery. Such efforts need to be systematized via integration into existing population-based substance use and broader public health surveys. Targeted interventions are not possible unless we are able to regularly measure with whom and where recovery is and is not flourishing. Recovery prevalence constitutes a valuable form of community recovery capital; we need to know if that capital is increasing or decreasing and what populations are and are not achieving recovery.

4. *Resolution and Recovery across the Severity Spectrum* Alcohol and other drug problems exist on a spectrum of severity, complexity and chronicity, and their course and outcome are highly influenced by levels of internal and external recovery capital. Studies of alcohol and other drug problems in clinical populations generally portray such problems as severe, self-accelerating over time, and resolved primarily through involvement in specialized addiction treatment, post-treatment recovery mutual aid participation, and lifelong drug abstinence. Studies of AOD problems in community populations conclude that most

such problems are mild to moderate, transitory, resolved without specialized professional care or formal peer recovery support, and are most often resolved via maturation, change in life circumstances, improved coping skills, and deceleration rather than complete cessation of drug use. The challenge we face as a field is avoiding indiscriminately transferring knowledge acquired from one population to the other as we disentangle, reconcile, and disseminate these findings.

5. *Pathways and Styles of Recovery Across Diverse Geographical/Cultural/Religious Contexts and Clinical Subpopulations* With and without complete drug abstinence. Sudden transformative change versus incremental change. Partial, full, and amplified recovery. Secular, spiritual, religious pathways of recovery. With and without embrace of a recovery identity. With and without participation in a recovery mutual aid fellowship. With and without specialized treatment. With and without medication support. Single versus multiple pathway involvement (dual citizenship in recovery). Pathway transitions over time in recovery. The risk of recovery pathways that inflict harm in the name of help. The work of mapping recovery pathways and styles is at an early stage and must be expanded and completed as a science-grounded guide for individuals, families, and caregivers.

Exploring the varieties of addiction recovery across diverse contexts has begun but is far from complete. The extent to which existing knowledge about addiction recovery is applicable across different geographical, cultural, or religious contexts remains unclear. There is evidence, for example, of distinct cultural pathways of recovery within communities of color, but the prevalence and variability of such pathways within these communities remains a mystery. Also unclear, is the potential for injury in the misapplication of mainstream concepts and practices drawn from existing research to populations not included within those foundational research studies. Given the long history of harm in the name of help in addiction treatment, such risk of iatrogenesis must be examined as future studies map the growing varieties of recovery experience and expose any potential risks for exploitation or harm found within those varieties.

6. *Recovery Across the Life Cycle* The bulk of what we know from the standpoint of science about addiction and recovery is based on studies of people entering specialized addiction treatment in mid-life at late stages of addiction. This resulting knowledge base has until recently excluded two critical groups: 1) adolescents and transition-age youth, and 2) older adults. How is recovery different when it is initiated at age 15 rather than at age 35 or 45? What special obstacles and opportunities exist when recovery is initiated early or late in one's life. Research touching on such questions can have life and death consequences. For example, there is considerable evidence that a point of recovery stability and durability is reached after 4-5 years of continuous recovery, but an exception to this rule exists among a subset of people who experience addiction recurrence after decades of recovery stability. What factors contribute to such recurrences? How can rapid re-stabilization of recovery be best achieved in these circumstances? These are the kinds of critical questions that lie unanswered within the existing body of addiction-related science.

7. *Stages of Recovery* Let's for a moment posit five stages of long-term addiction recovery: 1) precovery—a period of recovery incubation/priming, 2) recovery initiation and stabilization, 3) transition to long-term recovery maintenance, 4) enhanced quality of global health and social functioning in long-term recovery, and 5) efforts to break intergenerational cycles of addiction and related problems. Nearly everything we know about recovery from the standpoint of science is based on the study of people in the stage of recovery initiation. If we consider the possibility that distinct stages of recovery exist and that support needs of individuals and families evolve across these

stages, then the mapping of these stages, identifying stage-dependent needs, and evaluating stage-sensitive recovery support interventions becomes a critical recovery research agenda item. We have yet to create a comprehensive model of how problem severity/complexity, recovery capital, and service needs evolve across the long-term stages of addiction and recovery.

8. *Social Transmission of Recovery* One of the central discoveries of the recovery advocacy movement is imbedded within the slogan, "recovery is contagious," meaning that recovery can be socially transmitted and does not depend solely on the ebb and flow of intrapersonal motivation. Where the latter is often conceived as a pain quotient ("hitting bottom"), recovery advocates extoll instead the role of hope conveyed by exposure to "recovery carriers/champions"—people who make recovery infectious based on the power of their personal story and the quality of their character. Such processes of recovery transmission require disentanglement and testing as to whether recovery prevalence could be significantly increased by elevating the density of recovery carriers within a social network or local community. This potential also calls for research into recovery cascades—sudden and dramatic surges in recovery initiation--and the factors that incubate and sustain such cascades. The key question is whether it would be possible to strategically shorten addiction careers and extend recovery careers, amplifying years of recovery achievements and reducing the cumulative toll of addiction-related harm to individuals, families, and communities.

9. *Family Recovery* Stephanie Brown and Virginia Lewis conducted one of the first in-depth studies on the effects of addiction recovery on the family and drew an unexpected conclusion. They found that recovery initiation could destabilize families whose relationships, roles, rules, and rituals had for years or decades been frozen into self-protective but toxic patterns over the course of active addiction. Depicting this demand for radical recovery readjustment as the "trauma of recovery", Brown and Lewis called for scaffolding of support through the family reconstruction process. Studies are needed that inform the family recovery process and that can guide caregivers in the design and construction of the most effective family support scaffolding. Considerable attention has also been given to the intergenerational transmission of alcohol and other drug problems, but far less attention to mechanisms that may be used to break such cycles and promote intergenerational resistance, resilience, and recovery.

10. *Recovery Management and Recovery-oriented Systems of Care* In the closing years of the twentieth century a growing number of recovery advocates and addiction professionals expressed concern that addiction treatment had become disconnected from the processes of long-term recovery—that far too many patients were being recycled through ever-briefer episodes of treatment without achieving long-term recovery stability. This sparked calls to extend acute care models of addiction treatment to models of sustained recovery management nested within larger recovery-oriented systems of care (ROSC), with systems defined not as the treatment system but the larger mobilization of recovery support resources within the community. Emerging ROSC models involved assertive outreach and early intervention, global and strengths-based assessment protocol, partnership- rather than expert-based service relationships, evidence-based and integrated treatment methods, assertive linkage to indigenous recovery resources, prolonged post-treatment monitoring and support, and, if and when needed, early reintervention. The application of chronic disease principles and practices from primary medicine to the most severe, complex, and chronic substance use disorders offers great promise but requires rigorous and long-term evaluation.

As research scientists, we isolate and evaluate the effects of narrowly defined interventions, but I suspect the greatest

breakthroughs in enhancing future recovery outcomes will not lie within a single new personal or environmental intervention. They will instead lie in finding interventions that when uniquely combined or sequenced generate dramatically amplified recovery effects. What might well lie in our future is the bio/psycho/social/spiritual equivalent of the cocktail that radically altered the course and outcome of AIDS. We need solutions that mirror the complexity of the problems we face. The future lies in moving beyond fixed treatment "programs" to "treatment and recovery support menus" whose clinical and non-clinical recovery support services can be personally combined and sequenced across the stages of personal and family recovery. Those of you here may well determine whether this is a random, intuitive, or science-guided process.

11. *New Recovery Support Institutions, Service Roles, and Recovery Cultural Production* For more than 150 years, recovery mutual aid societies and professionally directed addiction treatment have coexisted as the two specialized institutions offering support to people seeking recovery from addiction. In the past 25 years, new recovery support institutions and roles have emerged that reach people at earlier stages of addiction and offer support over the long-term course of recovery. These new institutions include recovery advocacy organizations, recovery community centers, recovery residences, recovery high schools and collegiate recovery programs, recovery-focused employment programs, recovery ministries, recovery cafes, and recovery-focused sports and leisure activities. Newly conceived peer recovery coaches and recovery support specialists are serving in a wide variety of contexts. And people in recovery are expressing and celebrating their recoveries through the vehicle of recovery cultural production in the arenas of language, literature, art, music, theatre, film, and public recovery celebration events.

Collectively, these represent efforts to expand community spaces/landscapes in which recovery is welcomed, supported, and celebrated. There is a robust body of scientific knowledge about addiction treatment and recovery mutual aid societies, but only a paucity of research on these new recovery support institutions/roles and the extension of intrapersonal research to studies of the physical and social ecology of addiction recovery.

12. *Flourishing/Thriving in Recovery* Traditionally, addiction recovery has been viewed as a process of subtraction—deleting drug use and its progeny of allied problems. But a singular message across most recovery pathways is that recovery is far more than just the removal of drug use and related problems. Recovery in the view of recovery advocates also involves processes of addition (enhancement in global health and functioning and positive reconstruction of the person-community relationship) and the potential for processes of multiplication (getting "better than well" via enhanced acts of citizenship and community service). The study of thriving, flourishing, and mindful citizenship is one of the exciting frontiers of recovery research. We know a great deal about the cost addiction inflicts on individuals, families, and communities, but, until recently, little if anything has been revealed about the assets that recovery returns to the community.

How

The third foundation question involves the processes through which recovery research should be designed, conducted, and disseminated. Put plainly, most of the published studies on addiction recovery have not been directly informed by people in recovery nor have the fruits of such research reached the people in greatest need of science-grounded information on recovery. In this regard, all recovery research efforts could benefit from earlier work on cross-cultural research and the risk of cultural appropriation. We must scrupulously avoid cultural theft: representing ideas and language drawn from recovering individuals and communities of recovery as our own creation without proper

respect, permission, acknowledgement, or explanation of the source and historical and cultural context in which such ideas and language were developed. There are two related issues and strategies of import: 1) the need for recovery representation, and 2) the potential for recovery research coproduction.

Assuring recovery representation within recovery research addresses three concerns: 1) the adequacy of recovery representation (beyond token inclusion), 2) the authenticity of recovery representation (avoiding the problem of "double agentry"—masking of hidden personal/institutional interests behind the claim of recovery status), and 3) diversity of recovery representation (demographic, cultural, and recovery pathway diversity).

Recovery research coproduction goes beyond representation to a state of co-ownership in which people in recovery participate with other research team members on an equal footing. This would mean that recovery representatives are involved in all aspects of a study, including topic refinement, instrument development, site selection, subject recruitment, crafting informed consent procedures, data analysis, interpretation of findings, selection of publication outlets, co-authorship or acknowledgement of contributions, selection of post-publication information dissemination outlets, and co-ownership of study data.

The goals of recovery representation and coproduction go beyond enhancing study quality to first adhering to the ultimate ethical guideline "First do no harm"—in this case, to recovering individuals and families and their associated social institutions. Recovery representation and coproduction will also help assure study utility. It is not enough to publish recovery research findings in access-restricted scientific journals via papers couched in the equally inaccessible arcane language of science. What is needed is not just the conduct of recovery research, but the liberation of recovery research knowledge to people for whom that knowledge involves life and death decisions. To that end, people in recovery have a key role in shaping the why, what, and how of recovery research and in shaping study conclusions, dissemination venues, and the language through which study implications are publicly communicated.

Coproduction involves reciprocity of benefit. If value (e.g. indigenous knowledge) is extracted from a community through a research enterprise, then analogous value should be returned to that community by those responsible for the conduct of the research. If value (e.g., profit, prestige) accrues to those leading a research enterprise, then analogous value should be shared with the subjects/community under investigation or their representative institutions. We have many topical and methodological aspects of recovery research to explore, but we must include in that process the ethics and etiquette of recovery research.

Closing

In closing, let me say that a now passed and aging generation of recovery advocates dared dream of a science of addiction recovery. We envisioned and worked for years towards a day when research scientists from diverse backgrounds would be called to pursue a well-funded recovery research frontier. Today with the opening of this event, our hearts are soaring. The degree to which our dreams will be fulfilled is in the hands of those of you here today.